

Do Population Policies Matter?

*Fertility and Politics in
Egypt, India, Kenya, and Mexico*

Anrudh Jain, Editor

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Do Population Policies Matter?

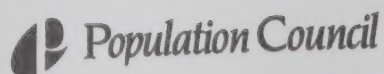
*Fertility and Politics in
Egypt, India, Japan, and China*

Arnold J. Toynbee

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The Population Council is an international, nonprofit, nongovernmental institution that seeks to improve the wellbeing and reproductive health of current and future generations around the world and to help achieve a humane, equitable, and sustainable balance between people and resources. The Council conducts biomedical, social science, and public health research and helps build research capacities in developing countries. Established in 1952, the Council is governed by an international board of trustees. Its New York headquarters supports a global network of regional and country offices.

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~ In loving memory of my parents ~

Sudarshan Lal Jain
and
Namo Kanta Devi Jain

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Foreword

Books about population and demographic change usually center around programs, social processes, and numbers. This book looks at the history and evolution of policy commitment underpinning four governments' population efforts over the past half-century. What are the essential elements of political commitment that will sustain a successful population program? Can the core features be teased out in a cross-cultural comparison? How should these features be assessed? Have foreign influences—primarily from the United States—really been motivating and sustaining factors? Does the gap between elite and public perceptions of population issues affect policy? These are some of the questions that this interesting book explores.

HISTORY AND POLITICAL CONVICTION

Egypt, India, Kenya, and Mexico began their demographic transitions at different times, under different political circumstances, and at different levels of economic development. India and Kenya, newly independent, seemed confident that the development policies they adopted would ensure improvement in the welfare of even rapidly expanding populations. Egypt and Mexico appeared similarly convinced that finding the right development formula could render population growth a neutral or even positive growth factor. Yet warning voices were heard also in all four countries. In Egypt, India, and Mexico some prominent intellectuals and thinkers had expressed concern in the 1940s, and even earlier, that continued rapid population growth could defeat development progress. Similar voices were heard in Kenya in the early 1960s.

INDEPENDENCE PERIOD

Each of the studies in this book details the ambivalence within governments about whether population growth was holding back the pace of economic development. Thus in Mexico, as Brambila records, intellectuals and academics, who have historically been influential in population policy formulation, more recently displayed little conviction on population policy—perhaps reflecting the continuing lack of international consensus among economists about the relationship between population growth and development.

For a political leader to launch a population program requires a high degree of conviction and courage. The voices opposed will be shrill, single-issue focused, and able to mount campaigns using the powerful symbolism of religion, tradition, and nationalism. Kenya and Mexico both had strongly pronatalist societies when their programs were launched; Egypt, a long tradition of large families and early marriage. Why then were the programs even begun? Certainly none of them sprang into life as a response to a visibly strong public demand.

The answers appear to support the thesis that population policies are top-down, emerging when elites become convinced that neither human welfare nor economic development goals will be achieved at high levels of demographic growth. A cross-country comparison suggests that there is nothing automatic about this conviction spreading through the layers of government officials. Egypt has shown at best an on-again, off-again support for population policy. Ibrahim and Ibrahim's fascinating survey of attitudes among Egyptian decisionmakers shows an indifference and lack of conviction prevailing even today on the significance of rapid population growth for the country's welfare. In Kenya, the 1967 antinatalist strategy introduced under Mboya was in abeyance for the next dozen years; Kenyatta was strongly opposed to any limitation of fertility. Only Indian policy shows a consistently strong concern about population growth, though with varying views of how to achieve the desired results.

It is interesting to compare the outlook of all of these countries with the policy climate in the Asian "tigers," whose energetic population programs in the 1960s and 1970s commanded widespread public adherence and acceptance, in part also due to better social setting. The early fertility declines that resulted in turn permitted much higher per-child investments in education and helped to promote rapid economic growth.

POLICIES AND PUBLIC MOTIVATION

Does the existence of a national demographic goal make a difference in motivating the public? Is a family's behavior influenced by the fact that the government wishes population growth to diminish? Each of the four countries studied had programs of public information that included strong appeals to have fewer children for the sake of national wellbeing. But economic realities did not seem to support the plea. Visaria and Chari point out that in India,

most people's lives had improved markedly since the 1950s, so that appeals based on the assertion that decreased population growth was essential for increased national prosperity did not correspond to the recent experience of most families. Kenya enjoyed agricultural growth of 6 percent during the 1970s, a figure almost twice as high as the remarkably high population growth figure of 3.4 percent. Again, there was public disbelief that high fertility and prosperity could not coexist. The surveys of Egyptian, Kenyan, and Mexican attitudes shows some, but not exceptional change in these beliefs over the decades.

THE ROLE OF FOREIGN INFLUENCE

And what of the foreign role? Certainly the US Government encouraged each of these governments at different times to adopt more active approaches. USAID designed country-specific policy presentations using computer-simulated forecasts of employment, public expenditures, and food needs at different rates of population growth; these were presented at the highest political levels in many countries. Foreign aid to family planning programs was made available in significant quantities, from a great variety of sources.

And yet these studies separately and together suggest that to see the idea of an active family planning program as a US creation is to miss the point. As noted above, serious thinkers in Egypt and India drew attention to the population problem in the 1930s and 1940s. The foreign funding of population programs has rarely exceeded 20 percent of the costs of the Indian program. Only in Kenya are external forces—principally the World Bank and the US—seen as having played the dominant role in policy determination. On the budgetary front, Kenya never saw itself paying for even one-half of the needed program expenses.

POPULATION POLICY AND PROGRAM DESIGN AND MANAGEMENT

India and Mexico both centralized their population programs to underline the national importance of the goals; in their federal systems this move ran counter to the state responsibilities for health and social welfare. In India the law of perverse consequences produced the result that less attention and less priority may have been accorded these programs by the local implementing agencies because they were always sure of getting this particular budgetary allocation. The difficulties that health departments have had in playing a coordinating role, and that stand-alone programs have had with health departments, are permanent features of the programmatic landscape of population policy in most countries.

These studies cast an interesting light on the role and impact of unfeasible demographic targets, which have persisted in most of these programs over a 30-year period. Egypt, India, and Mexico each at some time adopted wildly optimistic to highly improbable targets, presumably to underline the perceived gravity of the situation and to spur the public to more urgent reconsideration

of family-size intentions. A common mistake was not to factor in improvements in life expectancy. The authors are less clear as to whether unrealistic targets served to discredit the policies and/or detract from their importance, although Visaria and Chari believe that this element is part of a general discrediting of the Indian family planning program that has occurred over the past two decades.

ELEMENTS OF POPULATION POLICY: FAMILY PLANNING AND BEYOND

But what is a population policy? Jain has done as much as anyone over the years to remind us that the provision of contraceptive and family planning services meets only the needs of those who would otherwise experience unwanted fertility. Those who strongly desire large families will be unlikely to change that view simply because of the proximity, availability, or quality of family planning services. Increase in desire for small families is essential for couples to control their childbearing by delaying marriage and practicing contraception made available through family planning programs. Desired fertility and the timing of childbearing are more likely to be affected by girls' education, legal changes, the availability of employment alternatives for women, social security, and better health services to reduce infant mortality and improve family wellbeing. These factors contribute as significantly as contraceptive availability to fertility decline at different stages of the demographic transition.

The reproductive health approach, however, is not as new as some would claim—particularly those who insist that all early family planning programs were totally and blindingly demographically driven. Some elements of reproductive health were included in earlier formulation of population policies. The first Kenyan population program was focused on reduction of infant mortality and fertility. In fact, as early as 1952, the Indian Planning Commission thought family planning should be endorsed to improve the health of mothers and children. Program services in Mexico have long been delivered through integrated primary health structures along with infant care and immunization elements. And in Egypt, the link between early marriage and rapid population growth has long been appreciated and was taken account of in setting the country's policy goals.

The fundamental problem, as pointed out by Jain in his introductory essay, was that increasing concern with demographic growth got translated into increasing pressure on family planning programs and on service delivery targets where these exist or existed. Such concern should have been translated into pressure for enhanced programs likely to produce more widespread desire for smaller families and later age of marriage: girls' education, improved health services to reduce infant mortality and improve family health, alternative and enhanced roles for women. Most often, the focus was on better target achieve-

ment by service providers. The reproductive health approach and the recommendations of the 1994 International Conference on Population and Development refocus attention on individual wellbeing.

Like most observers, the authors of these studies have a tendency to make their judgments about the importance accorded to population issues primarily with reference to the importance accorded by the government to the availability and functioning of family planning services. The exception is Ajayi and Kekovole, who credit the gains of the Kenyan program to the government's success in increasing school enrollment and improving health care. The link between education, particularly girls' education, and fertility decline has been established and appreciated for many years. One imagines that some governments would not have been insensitive to this linkage and might have been more inclined to promote girls' education because of an anticipated effect on population growth.

CROSS-SECTORAL POLICY ELEMENTS: MAKING IT HAPPEN

Even if a full appreciation of the determinants of fertility were to exist in the policymaking circles of a given country, effective implementation and coordination of a population program would by no means be assured. There should be no surprise that it is difficult or impossible for these governments, indeed any government, to mobilize a cross-ministerial, cross-sectoral, integrated program that would contain all the elements necessary to reach their desired demographic goals. This kind of integration and coordination is rarely achievable in any field under peacetime circumstances, and is achieved in times of conflict through extremely powerful temporary coordinating entities.

In normal times, governments pay varying degrees of adherence to cross-sectoral strategies, depending on the power of the coordinating entity to affect resource allocation, and on the degree of importance accorded by the ministers' or departments' normal constituencies to the new elements. For example, a government may adopt an environmental strategy, but the adherence of the forestry and energy departments to it will depend on the impact on those who derive their incomes from the forestry and energy sectors.

Contending policies—even those directed toward the same broad goals—may also produce effects at cross-purposes. In Egypt, India, and Mexico, family welfare is the objective of both the family planning and the family subsidy and allowance programs: one discourages large families while the other implicitly rewards them.

Population policies have never commanded a campaign-like adherence across ministries and sectors, although more attempts have been made to achieve such a result than might be imagined. None of the governments discussed here succeeded to any major extent in promoting the kind of cross-sectoral, cross-ministerial coordination that a truly effective, truly integrated population policy would require—linkages to social security policy, inherit-

ance, girls' access to all levels of education, and so forth. This is partly a reflection of the fact that population issues have indeed been seen as the purview of the health ministry or of a vertical stand-alone family planning offshoot. It is also a reflection of the fact, just mentioned, that such coordination is extraordinarily difficult for governments of all countries at all levels of development. At the same time, the need for coordination was recognized in each of the countries, and each of them established mechanisms, often presided over at the highest political level, to try to draw the different sectors together. The results were much less than desired.

What can be done to foster cross-sectional population policies as envisaged in the ICPD Programme of Action? There is no easy answer. The authors of the country studies and Jain in his concluding essay address this important issue. As a general rule, success depends on the homework done before the policy announcement, the strength of the coordinating entity, the resources available to promote implementation, and the sanctions that will actually be applied at the highest political level if the policy is not promoted.

I commend this book to serious students of population policy and to those who have puzzled over why good policy seems so difficult to implement. The book answers an appreciable number of the relevant questions, and its authors have done us a service.

MARGARET CATLEY-CARLSON
President
Population Council

Preface

The extent to which effective public policies are articulated and implemented often depends upon the degree of political commitment to the ideals imbedded in them. A policy can be thought of as a government's guiding principle or intended course of action on a matter of national significance. Policies in this sense are a formal articulation of a government's current thinking on a given subject.

Policymaking, influenced by a number of internal and external factors, requires a balancing of national, group, and individual interests. Policymaking in developing countries prior to their independence was guided by the interests of colonial powers. There was congruity among domestic interest groups. While their participation in policymaking was limited, it was guided by the common national interest. Different leaders (freedom fighters, for instance) and groups (religious, tribal, and political) worked together on the mutual goal of achieving independence from colonial rulers. Following independence, policymaking in these countries underwent substantial change; policies increasingly began to be influenced not only by national interests but also by group and individual interests. Policies oriented to achieving a national goal, for example economic development, are now influenced by struggles among political leaders and political parties either to come to power or to remain in power.

Policy outcomes in countries open to influences from outside the government (both from within and outside the country) are able to reach a compromise between competing interest groups. In others, where government systems are less permeable, the interests of one person or one group determine outcomes. Irrespective of how policies are determined, it is important to recognize that they are aspects of a broader national agenda. Taken together, various poli-

cies help advance a country's long-term objectives and determine people's wellbeing.

The formulation and implementation of population policies emerge from domestic and international conditions that affect the outcome of other public policies as well. The four case studies included in this book address the question "Do population policies matter?" by examining population policymaking and the politics surrounding it from historical and contemporary perspectives in individual country contexts. These studies illustrate how and why the formulation, implementation, and effectiveness of population policies vary over time within and between countries.

To understand whether population policies matter, we need to see them as part of a broader process. Although all policymaking processes share certain patterns and rules, population policy is different in some ways. A government that outlines a population policy is, in effect, proposing to categorize, codify, and ultimately alter the most basic human behavior related to sexuality and reproduction. This confers broad power to those individuals involved in formulating such a policy, including those willing to support or oppose it. This is especially so in countries where such behavior is already codified and regulated by religious and cultural traditions.

Given the religious and cultural barriers a population policy must often overcome if it is to be successful, why do some political leaders appear willing to risk loss of popularity and even their power to pursue population objectives? Indira Gandhi, many have said, lost the 1977 election in India because of her government's coercive sterilization program. What then drives a government to pursue one of the most politically risky and controversial types of policies and programs? This is a complex story that requires consideration of internal goals and aspirations, as well as external ideas and intervention.

Following closely behind national security concerns, national development, especially economic development, continues to be the primary impetus to policymaking in most countries of the world. This was particularly the case when most developing countries gained political independence in the 1950s and 1960s. Their development and modernization led many countries to seek financial assistance to build political institutions and social infrastructures. International donors and agencies in the West emerged to meet this need, but often with a proviso attached: that efforts to limit rapid population growth be part of the development package.

The international debate about population issues since then has focused on two main topics: the rationale for reducing population growth in developing countries, and the legitimacy of the means used by governments to reduce high fertility. Interestingly this debate assumes little or no migration of people from developing to developed countries, whereas, historically, the effect of high population growth in Western Europe was mitigated in part by migration to the United States and elsewhere in the Western Hemisphere. The effect of not including migration in the international debate on population policies has been

that coercive means at times are legitimized to control fertility and therefore to reduce population growth.

The rationale for reducing the rapid population growth rate is usually expressed in terms of its being beneficial at the aggregate level, while the benefits to be derived by individuals are implicit but rarely specified. The legitimacy and effectiveness of various approaches used by national governments have been debated as well. It is commonly agreed that family planning programs oriented to provide contraceptive services and information would reduce overall fertility by helping individuals to reduce unwanted childbearing. But what governments should and could do to lower fertility in societies with high fertility norms remains a contentious issue in the arena of population policymaking. The contention in part revolves around the premise that those who are asked to bear the burden of fertility reduction do not necessarily share the potential benefits of the reduction in population growth.

How are effective population policies articulated and implemented? Have international agencies played a strong role in prompting developing-country governments to adopt and implement strong population policies? How has the international debate influenced deliberations on population issues in developing countries? The impetus for the four country studies presented below was provided by a desire to better understand some of these issues within specific contexts.

Four countries—Egypt, India, Kenya, and Mexico—were selected because of their demographic weight, a long history of population policies and programs, and evidence of fertility decline. Each study was written by a local investigator or investigators—whether citizens or long-term residents of the respective countries. The selection of investigators to write about countries with which they are intimately familiar may entail some loss in objectivity; however, it has the advantage that they understand the particular social systems and are sensitive to internal political currents. The quality of the four studies and the depth with which their authors cover various issues, nevertheless, suggest that in these cases the advantages outweigh the potential disadvantages.

The investigators from Egypt, India, and Kenya first met in November 1993 in Cairo to discuss the design of these studies. They met again in Mombasa, Kenya in July 1994 to review progress, at which time Mexico was added to the list to expand the range of geographic experience. Preliminary findings were presented at the Forum of Nongovernmental Organizations at the International Conference on Population and Development (ICPD), held in September 1994 in Cairo.

The methodology used in these country studies is unique. Each study is based on sources that reflect perceptions of population policies and issues within a country: analyses of official documents, public statements, parliamentary records, mass media, and religious commentaries. In addition, the investigators from Egypt, India, and Kenya collected primary data through interviews and focus group discussions with political and religious leaders,

professionals and bureaucrats involved in the implementation of population policies, NGO activists, and men and women who determine the ultimate effectiveness of population policies.

The analyses of formal policy statements address such questions as: What is the range of concerns envisioned? Do they include mortality, migration, and urbanization, as well as fertility? What is the main rationale for a population policy—to promote socioeconomic development, individual wellbeing, health? What are the means selected to implement the policy and how are those means controlled?

Issues related to the course of a population policy include: How did population policy evolve, who was involved, and how was policy formulation influenced by internal political systems and by international agencies? What effect did the type of training that professionals from a country received have on the content of policy and program style? What were the roles of external financial resources, of the availability of technical assistance (such as consultants and review teams), of political leaders, of technocrats and professionals, and of major events such as civil disruptions and natural disasters?

The second set of issues each country study addresses relates to how population policy is actually implemented. What administrative structures guide the program and provide coordination? What are the operational links at the levels of the state, district, and community? What is the degree of flexibility and autonomy at the local level? How are resources organized and what is the balance between external and domestic resources? The country studies examine the influence of many other forces on the design and implementation of population policies. These forces include: the form of the governmental regime; the degree of commitment and competence of political leaders, bureaucrats, technocrats, and professionals; available financial and personnel resources; institutional and administrative structure; and the role of religious leaders, NGOs, and mass media.

In order to examine the role of exogenous events, the authors of these country studies compared the performance of a population policy with the performance of education, health, or economic policies. This helped them to ascertain whether such factors as political instability or lack of political commitment, often blamed for the limited success of a population policy, have in fact more broadly affected the success or failure of policies in other sectors of development.

Finally, the authors extrapolate from their findings to speculate on the future of population policy within the countries under consideration. They identify points of agreement between various stakeholders about the nature of population issues facing them and the country and identify potential solutions for political and cultural conflicts faced in addressing those issues.

In a collaborative effort of this kind, it is not possible to incorporate all the unfolding events that might affect the formulation, implementation, and effectiveness of a population policy in a country. For example, as this book was getting ready to go to press, the United States announced sanctions against India following the underground nuclear tests conducted in May 1998. There was

no time to ascertain the extent to which these sanctions will take effect and to analyze their implications for India's ability to mobilize resources required for implementing the revised reproductive and child health approach to population policy.

These studies would not have been possible without the collaboration of the investigators and the financial support provided by the JDR 3rd Fund, the Pew Charitable Trusts, and the Population Council. I acknowledge with thanks the administrative and research assistance provided by Raji Mohanam in preparing this book. Valuable comments received from Judith Bruce, Ruth Dixon-Mueller, and Warren Robinson on earlier drafts of the entire manuscript are also acknowledged with gratitude. I also thank Robert Heidel and Alice Tufel for editorial assistance, and Sura Rosenthal and Christina Tse for the production of this book.

ANRUDH JAIN

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Population Policies That Matter

The politics of fertility control is not limited to whether leaders in a country are convinced there is a problem, or to whether they make public statements about the need to reduce rates of population growth. The politics of fertility control is about the power and control exerted by various stakeholders over individual lives and limited resources.

The politics of fertility control is about the role of the state in regulating individual behavior. It starts with the specification of the rationale for government involvement in policies to alter human behavior related to reproduction and sexuality. It involves justifying the means selected by a government to influence individual fertility behavior. Politics is also about the influence academics and intellectuals exert on fertility-reduction policies at both the national and international levels. Politics is about the role of international donors, who are influenced by the political climate within their own countries, in designing policies to reduce fertility in developing countries. Politics at the level of implementation is about the behavior of bureaucrats, which in turn is conditioned by the structures of governments and donor agencies. Finally, the politics of fertility control is about the control one class or ethnic group exerts over another, and about the gender relations within and beyond the household.

The evolution of population policies in developing countries as illustrated by the four country studies in this book has been guided by a concern that rapid population growth hinders economic development. The underlying rationale for this concern, though not always stated explicitly, has been to reduce poverty and to improve individual wellbeing.

This introductory chapter draws on the material in the four country studies to make some broad generalizations about the politics of fertility transition

over the past several decades. The concluding chapter speculates about what might occur in the future, particularly as countries continue to adopt and implement recommendations of the Programme of Action agreed upon at the International Conference on Population and Development.

EVOLUTION OF POPULATION POLICIES

Each country examined in this book experienced a gestation period of internal debate on population issues. The duration of this period—the time between the recognition of the problem and the formulation of an implementable policy—was fairly long in all countries. A population policy, by definition, should address the population issues or problems as they are perceived by the people of a country. As illustrated by the four studies, however, such is not always the case. People do not always perceive population size or a rapid population growth rate as a pressing problem facing them or the country in which they live. Nevertheless, population policies in these and other developing countries are often designed to reduce the high rate of population growth. This articulation of the population problem has been guided primarily by the national (macro-level) interest of economic development,¹ and it is influenced by Western thinking based on demographic and economic modeling (see, e.g., Coale and Hoover 1958). The process of policymaking in this sense has been top down.

Developing-country participation in the policymaking process in the 1950s and 1960s was limited to a handful of academics, mostly those educated in the West. Although they had links with decisionmakers, these links were often informal. The situation at the close of the century is different. While participation in the process is still largely limited to the “policy elite,” the latter are guided more by interest groups (e.g., ethnic, regional, or religious) and less by national interests. Recently, women have emerged as significant players in the population debate, a circumstance that has enlarged the scope and participation of people in the process. This will continue to have a profound effect on the nature of population policies and the ways they are implemented in developing countries.

A formal policy statement must include goals and objectives, a rationale, and an implementation plan. While formal articulation of population policy in these four countries expressed concern with fertility, mortality, urbanization, and migration, it rarely included plans to alter mortality and migration patterns. These are specified in a country's policies related to health, rural development, and migration. Since a reduction in the rate of population growth, in the absence of high mortality and international migration, can occur through fertility reduction, population policies specified a plan to modify only one component of population growth—fertility. This implementation plan, however, did not fully take into account the existing knowledge about the determinants of fertility or theories of fertility decline (see, e.g., Mason 1997 for a recent review of theories of fertility decline). Although early frameworks of fertility behavior recognized the importance of societal and institutional factors in

determining individual fertility behavior (see, e.g., Davis and Blake 1956; Freedman 1961/62), the implementation plans have focused primarily on the organization of family planning programs, with the goal of reducing fertility in all settings irrespective of the prevailing fertility norms in the society.

Population policies did not specify programs and means to influence those factors at the individual or community level that affect women's desire and need for large families. These factors include infant and child mortality; women's education, employment, and empowerment in general; and the economic conditions of the community and the country. Programs to influence these factors are included in a country's health, education, and development plans, which are guided not by the objective of fertility reduction but by the objective of national development.

The organization of a family planning program has been the main (or only) implementation arm of population policy related to fertility reduction in all four developing countries, as in many others. In other words, these programs were assigned and assumed the *sole* responsibility for reducing population growth and fertility (see, e.g., Jain 1989). However, the scope of activities within a family planning program varied greatly over time within and between countries. These activities included but were not limited to the provision of information about and services for contraceptive methods, propaganda or motivational messages through the mass media, incentives to providers and clients, and method-specific quotas. The progression from service delivery to more stringent measures depended upon the gap between the desired and actual pace of fertility decline in a country.

Family planning services are typically provided through the Ministry of Health. In Egypt and Kenya, nongovernmental organizations have also been important providers of services, whereas in India the Department of Family Welfare within the Ministry of Health has been responsible for service provision. Pharmacies and the private sector have played an important role in Egypt and Mexico. In Egypt, Kenya, and Mexico, independent population organizations were created to coordinate activities of different ministries and departments. At present, this function is the responsibility of the Planning Commission in India, but there have been various proposals to create a separate population commission in that country.

The function of these population bodies, however, has been limited to coordination of various agencies that provide contraceptive services and information and to acting as liaison with international agencies. Their activities do not include influencing investment patterns in other ministries to achieve the goals of population policy. When population growth and fertility failed to decline at a desirable pace in India, for example, planners searched for potential interventions within the family planning program. This resulted in movement from provision of voluntary services to incentives to clients and providers and to more stringent method-specific quotas.

In sum, a tendency to equate population policy with family planning programs is both semantic and real. It resulted from the following three factors:

—an interpretation of population policy to mean solely a fertility-reduction policy;

—the use of the label “family planning programs” to encompass all means of inducing fertility decline, ranging from voluntary contraceptive services to community-wide incentives and coercion; and

—little or no effort to influence investment patterns in other sectors of development to achieve the overall goal of fertility reduction.

EFFECTIVENESS OF POPULATION POLICIES

The best way to measure the effectiveness of an intervention is through experimental and quasi-experimental designs, which are rare in this field. In the absence of such designs, it is difficult to establish a cause and effect relationship between the formulation or implementation of a population policy and a decline in population growth or in the fertility rate in a given country. For example, one may be tempted to conclude that a country’s population policy is unsuccessful if the fertility rate is not declining and to conclude that the policy has become successful as soon as the fertility rate starts to decline. Such thinking is tautological. Nevertheless, this is what happened in the interpretation of fertility changes in Kenya. As pointed out by Ajayi and Kekovole in Chapter 4, early investments in education and health contributed to the success of the family planning program in reducing fertility in Kenya. Since population policy in almost all developing countries is implemented through organized family planning programs, the effectiveness of these programs depends on their design, on the indicator used to measure their effect, and, above all, on the social, economic, and cultural settings in which the programs are implemented.

Numerous studies have tried to estimate the relative contributions of family planning programs and social and economic changes to fertility decline by using statistical controls and aggregate data for multiple countries (see, e.g., Bongaarts, Mauldin, and Phillips 1990). No attempt is made here to review that literature, except to note that variations among countries in the scope and design of family planning programs make it difficult to assess the impact of “voluntary” programs in reducing fertility. This is because the index, “program efforts,” used to measure the strength of each country’s family planning program does not distinguish between the voluntary and involuntary components of a program. (See Lapham and Mauldin 1985 and Mauldin and Ross 1991 for the measurement of program efforts index; and Jain and Bruce 1994 for some of its limitations and their implications for drawing inferences about the effectiveness of “voluntary” family planning programs.)

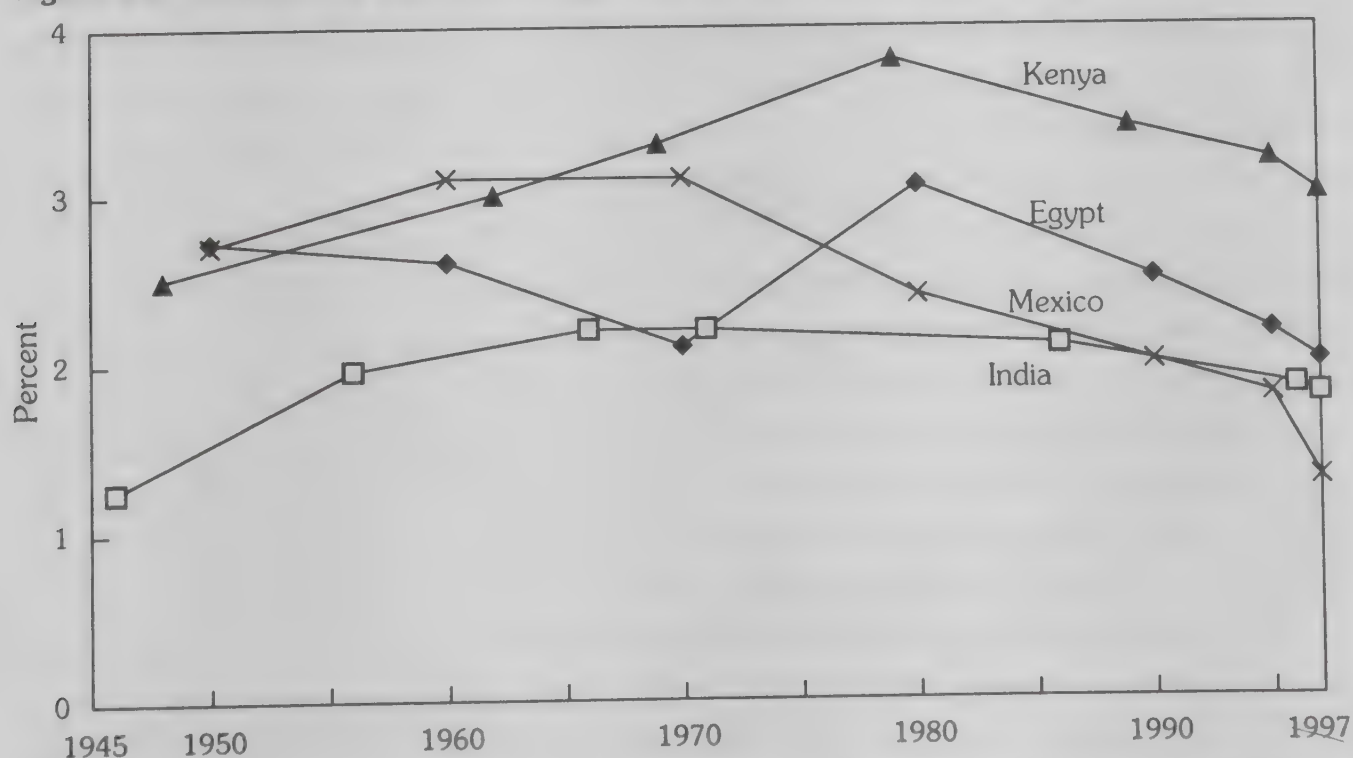
At times, the reported effectiveness of a program is conditioned by the point of view of the analyst—for or against the intervention. Proponents of family planning programs usually interpret a decline in fertility as an indication of the success of these programs, whereas detractors interpret it as reflecting changes in broader socioeconomic environment (see, e.g., Robey, Rutstein,

and Morris 1993; Pritchett 1994a; and the exchanges between Knowles, Akin, and Guilkey 1994, Bongaarts 1994, and Pritchett 1994b).

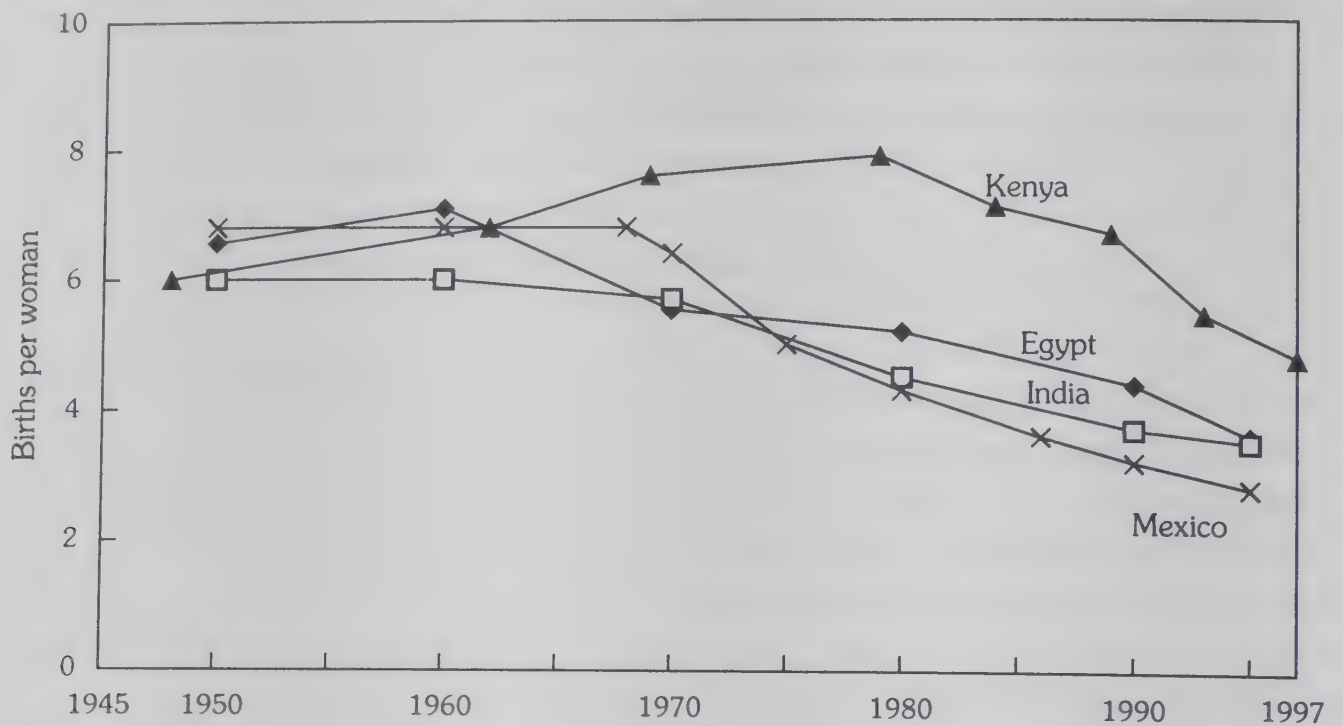
Both the actual (measured) and the perceived effectiveness of a country's family planning program are affected by the indicator used to measure its effectiveness—whether population size, population growth rate, birth rate, total fertility rate, or contraceptive prevalence rate. The population growth rate in India, for example, remained virtually constant over the three decades between 1961 and 1991. As indicated by Visaria and Chari in Chapter 3, a lack of decline in the annual population growth rate created an impression within and outside India of the failure of its population policy and family planning program. In fact, India's birth and death rates have declined by the same order of magnitude, which means, in effect, that both the health and the family planning programs have been successful. By comparison, recent success in Egypt, Kenya, and Mexico was achieved after population growth rates in these countries, as a consequence of mortality decline, had increased and remained high for about two decades (see Figure 1.1). In these three countries, fertility decline followed a substantial decline in mortality, whereas in India births and deaths declined simultaneously.²

The total fertility rate (TFR) in all four countries has declined (see Figure 1.2). In Chapter 5, Brambila infers the effectiveness of Mexico's population policy from observing that the pace of decline in the TFR prior to the policy in the late 1960s and early 1970s was slower than the decline between 1975 and 1981. Similarly, the decline in the TFR in Kenya between 1979 and 1989 was much slower than between 1989 and 1993. The decline in the TFR was slowest between 1970 and 1986 in Egypt. As pointed out by Ibrahim and Ibrahim in Chapter 2, this period coincided with post-Bucharest rhetoric about develop-

Figure 1.1 Annual rate of population growth in four countries, 1946–97 (percent)



Source: Data based on national censuses, surveys, and registration systems (supplied by authors of country studies).

Figure 1.2 Total fertility rate per woman in four countries, 1948–97

Source: Data based on national censuses, surveys, and registration systems (supplied by authors of country studies).

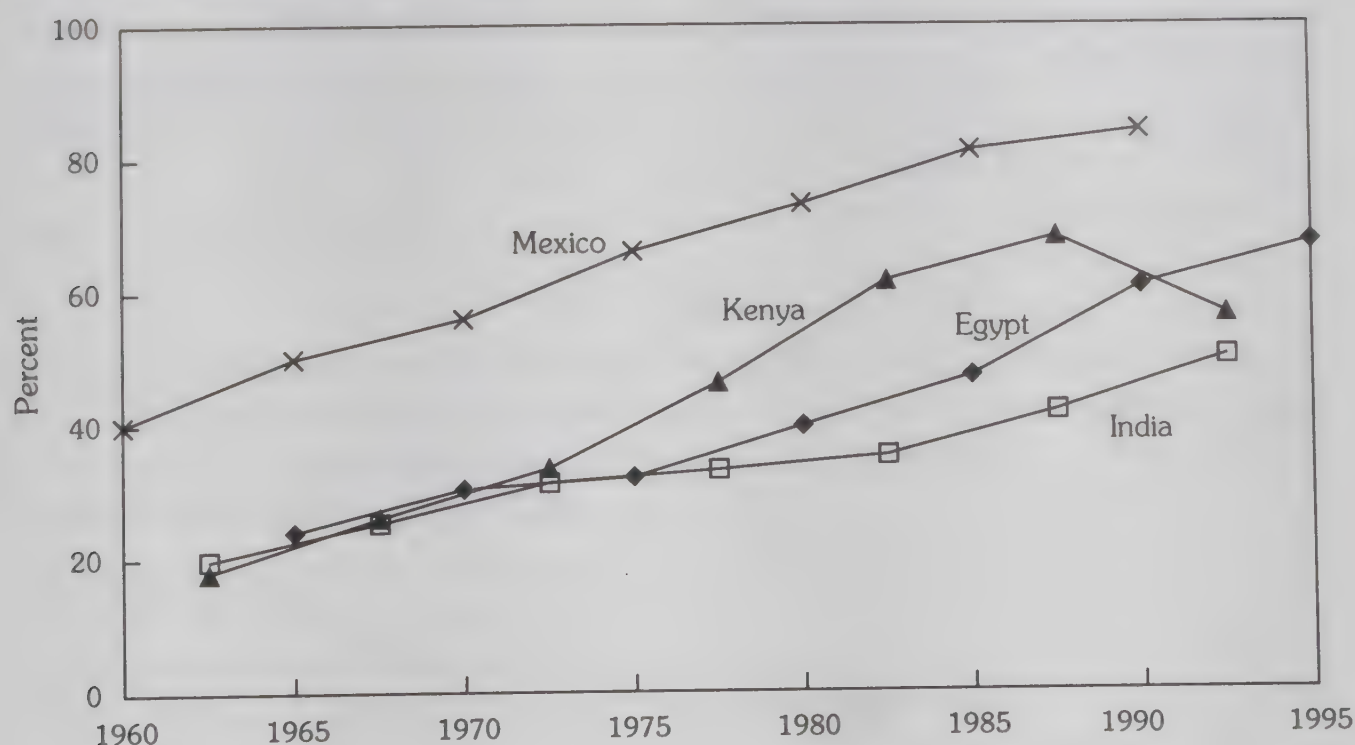
ment and a lack of top-level commitment to population policy. The fact that the infant mortality rate was relatively low and female education was relatively high in Kenya and Mexico before fertility started to decline suggests the importance of these factors in the relative success of family planning programs in reducing the TFR. The slow pace of fertility decline in India may be in part due to high infant mortality and low female education—conditions unfavorable to the desire for smaller families.

Fertility declines in Egypt, India, and Mexico took place while educational achievements were rising. On the other hand, the onset of fertility transition in Kenya seems to have coincided with a downward trend in the education of children. Ajayi and Kekovole hint at the negative effect of structural adjustment policies on children's education. The data presented in Figure 1.3 provide evidence of such an effect in the 1980s in Kenya.

Figure 1.3 shows the percent of females 15–19 years of age who have at least a primary school education.³ The educational achievement of females aged 15–19 increased in all countries throughout the 30-year period except in Kenya. Educational achievement in Kenya shows a sharp drop in the last five years, which could reflect the impact of structural adjustment policies in the 1980s on parents' ability to bear the cost of education. Similar trends are observed for females completing at least secondary-level schooling and for males at both the primary and the secondary levels.⁴

The considerable variation in fertility trends by geographic area within all four countries is usually interpreted as reflecting the differential success of family planning programs. However, such an inference may not be accurate: areas with high fertility and low contraceptive prevalence in these countries are also areas with low female literacy and high infant and child mortality—social set-

Figure 1.3 Percent of females aged 15–19 years with at least a primary school education, four countries, 1960–95



Source: See endnote 3.

tings less favorable to small family size desires (see, e.g., Jain 1985 and 1998 for the role of these two factors in explaining regional variations in India).

In sum, the data reviewed here point to the difficulty in ascertaining a cause and effect relationship between policy intervention and demographic change. The task of identifying a common set of factors responsible for fertility transition becomes even more difficult. Nevertheless, conditions favorable to fertility decline seem to include low infant and child mortality, high female literacy and education, and a family planning program that provides information and services for contraceptive methods. The roles of other factors are described next.

PARTICIPANTS IN POPULATION POLICYMAKING

A host of actors within and outside the government influence the policymaking process. Some of these players are common to all four countries. International donor agencies (UNFPA, USAID, World Bank), private foundations (Ford, Rockefeller), and international NGOs (IPPF and its affiliates, Population Council) are a few examples. There are also actors or circumstances whose roles have been unique to each country: the Catholic Church in Mexico, Islamic activists in Egypt, tribal politics in Kenya, and party politics in India. The power these key players exert often goes unrecognized in standard population policy analysis.

Political Leaders and Political Commitment

The critical role of political leaders in the arena of population policy is documented in each of the four country studies. Usually out of reaction to various

pressures from internal and external forces surrounding them, political leaders can often be the keys to unlocking the various "policy doorways" available to a country. The most common participants in the political leadership of a country are the chief executive, ministers/cabinet members, and individuals from the legislative body. These elites often compete for scarce resources, making population policy decisions highly politicized and diffuse.

Leaders in Egypt and Kenya saw population size as "good" for the country:

Numbers = Power = Strength = Good.

President Nasser of Egypt did not recognize the impact of rapid population growth during the first decade of his presidency, and President Sadat paid little attention to the problem throughout his tenure. President Mubarak paid scant attention to population for the first three years of his presidency. His interest varied considerably in the late 1980s, but he has taken a direct and renewed interest in the issue since the early 1990s. All three leaders came from a military background, where the demographic weight of a country is seen as a strategic advantage. The population issue in Kenya was accorded the lowest priority on the political agenda following the country's independence in 1963. The majority of political leaders at the time were influenced by socialist paradigms, and felt that rapid socioeconomic development would solve any problem facing the country.

Population policy in Mexico remained pronatalist until the early 1970s. The adverse consequences of population growth were beginning to be felt with a slowdown in economic progress in the 1960s. In their capacity as public officials, consultants, and advisors to high-level government officials, Mexico's intellectuals played an important role in influencing policymakers about demographic issues. This contributed to the turnabout in Mexican population policy. Brambila speculates that the change in President Echeverría's thinking, however, came from his firsthand knowledge of population control programs in socialist countries, including China and Cuba, both of which he visited during his administration.

Concern over population growth in India was expressed as early as 1940, when a subcommittee on population established by the Indian National Congress considered "family planning and limitation of children" essential for the interests of social economy, family happiness, and national planning. Nevertheless, except for the short Emergency period during the administration of Indira Gandhi, political leaders generally have refrained from addressing the population issue publicly. It appears on the political agenda mainly in the form of a concern over an imbalance of representation of various groups in the national parliament.

The commitment to policy and its implementation within a country decreased as the distance from the leadership increased. Within the bureaucratic structure, this can be seen in decreased commitment as one moves toward lower levels in the hierarchy. For example, while President Mubarak took direct and renewed interest in population issues in the early 1990s, few senior policymakers until recently recognized population growth as a major problem facing Egypt. In terms of geographic distance, decreased commitment can also

be seen as one moves from the national capital to rural areas. For example, a strong political commitment to reduce population growth in India led to forced vasectomies during the Emergency period of Mrs. Gandhi, but commitment to this policy decreased as one moved away from Delhi, the seat of power. The policy in the northern states was implemented with much more vigor than in the southern states.

Political commitment can have a negative or positive effect on policies and programs related to fertility transition depending upon the context and the nature of such commitment. The commitment to population policy varied over time within and between countries. Political commitment at the highest level in Kenya and Mexico was essential for the implementation of an effective policy. However, a strong political commitment, because of the way it was implemented, produced a long-lasting backlash in India.

Religious Groups

Religious groups and their doctrines have proven to be one of population policy advocates' fiercest opponents. Religion, by its nature, pronounces its laws and edicts as ultimate and immutable truths. This is especially so in its codification of sexual and reproductive behavior. Through this authority, religion has had a powerful role in many countries' population programs. In the four countries included in this book, however, the role of religious groups—though pervasive—did not have a decisive impact on population policy implementation. The Catholic Church in Mexico and Kenya, Islamic leaders and groups in Egypt, and Hindu and Muslim groups in India all had limited effects—usually in the form of a slowdown—but did not determine the final outcome of population policies.

In contrast to its influence in other Latin American countries, the Catholic Church in Mexico was not powerful enough to stop the government from pursuing its various population policy initiatives. It could not defeat efforts like the 1973 Population Law due to the fact that, since 1880, separation of State and Church existed in Mexico. In addition, the Catholic Church did not attack the national family planning program, as it did in other Latin American countries, but restricted itself to condemning the use of contraception. This in the end, however, did not influence women's contraceptive behavior.

Although the Church has been a historically forceful presence in Kenya, it has not had much influence on the reproductive behavior of Kenyans. High fertility levels may be better explained by the deep-seated cultural and traditional beliefs in the need for begetting children. In Kenya and in other parts of Africa, traditional beliefs dictate that one's immortality is largely dependent on the number of one's descendants. Children become the means by which ancestors, who are central figures in traditional rituals and customs, are remembered (Kokole 1994).

The pronatalist stance of the Coptic Church and of the Imams of Islam, both of which are prevailing forces in Egypt, could have jeopardized the success of population policies there. However, they did not. Socioeconomic development quickly became the country's primary objective during the 1960s, at a

time when the government first recognized rapid population growth as one of the biggest barriers to this goal. The slow progress made by Egypt in implementing population policies was influenced to some extent by a spread of radical Islamic and radical socialist ideologies, both with a strong pronatalist stance. A curious alliance between the two in fact threatened the successful completion of the ICPD in Cairo. That these forces did not succeed in monopolizing Egypt's public policy arena was attributable to the fact that, as pointed out by Ibrahim and Ibrahim, the government has several actual and potential allies in the bureaucracy and in civil society.

In the Indian context, religious views on population can be highly politicized issues. The issue of religious influence on population policy is less of a philosophical and theological matter in India than it is an electoral issue. In regions with a demographic imbalance of Hindus and Muslims or of Hindus and Sikhs, the minority in question often perceives fertility-control measures as an attempt to decrease its numbers and, therefore, its political leverage (Panandiker and Umashankar 1994). At the national level, on the other hand, religion has had no important role in the implementation of population policies.

Ethnic Groups

The concerns of ethnic communities, especially when they are minority populations, pose new challenges to a country's population policy and its programs. Ethnic groups exert political pressure to varying degrees in each of the four countries. To what extent they have an effect on population policy depends largely on their electoral strength and how the government perceives them as a force to contend with. Ethnic diversity has resulted in the complex power struggles of tribal politics in Kenya. Hundreds of linguistic, religious, and caste groups in India vie for representation in the government. Indigenous groups in Mexico, such as Nahua, Maya, and Otomi, have been traditionally isolated from the political, social, and economic processes of the country. Ethnic diversity has been of lesser importance in Egypt, with a highly homogeneous culture incorporating both Muslims and Copts. In each country, ethnic diversity has had less of an influence on population policy formulation than on the acceptability and implementation of family planning programs.

Feminist Factions and Women's Groups

Only in the last decade have feminists begun to exert a major influence on population policy formulation. Their importance was clearly recognized at the 1994 Cairo Conference on Population and Development and at the 1995 Beijing Conference on Women. At both forums, women's groups helped to advance the notion of integrating comprehensive reproductive health services and gender equality within population policy. At these conferences, governments began seeing feminist and women's groups as significant constituencies. Nonetheless, these groups face discrediting attacks in all four countries for being too closely identified with Western feminist agendas.

The country studies show that women's groups and organizations have made governments increasingly aware of the adverse effects that the inappropriate use of contraceptive methods can have on women's health. Many feminists criticize policymakers for being concerned only with the demographic goals of lowering fertility levels while ignoring the implications of this approach for women's wellbeing and reproductive choices. Increased information exchange and dialogue between governments and women's organizations have helped to improve understanding and sensitivity on both sides.

Nongovernmental Organizations

Nongovernmental organizations (NGOs) continue to be among the most influential actors in the policymaking process. Donor agencies and international NGOs have greatly influenced the economic transformation in many developing countries and, in so doing, have set the agenda for their population programs. NGOs act as "buttresses" to the government's family planning initiatives. Without them, many countries could not effectively implement ambitious plans for improving the quality and expanding the scope of family planning services.

By nature, NGOs have the advantage of not being burdened with the bureaucratic inertia of a government agency. NGOs are in touch with their constituencies and can act swiftly and independently to advance a country's population agenda. By providing technical information to policymakers, NGOs educate government officials on various aspects of the population issue. The better informed policymakers are on technical issues, the more likely they are to make intelligent decisions on policy options, in turn resulting in more effective and sustainable population policies. Domestic NGOs, including IPPF affiliates, have demonstrated that services can be provided and that people want and use these services. This demonstration has encouraged governments to invest resources in expanding service facilities through family planning programs.

Census and Survey Information

Timely availability of accurate data about trends in fertility and contraceptive prevalence has played an important role in creating enthusiasm among planners and program managers about the importance of services in reducing fertility, especially in Egypt and Kenya. The lack of timely availability of accurate data about trends in fertility and contraceptive prevalence in India, on the other hand, probably contributed to a widespread perception of the failure of its population policy. In the absence of accurate information, the effectiveness of India's population policy was gauged by population growth rates estimated from decennial censuses. A lack of decline in annual population growth rates over three successive decades was interpreted widely, both within and outside India, as a failure of its population policy and family planning program. It is possible that the Indian program would not have become as coercive as it did, if planners and social scientists had had access to timely information on fertility trends. India's mistrust of the international community, moreover, contrib-

uted to the country's nonparticipation in the World Fertility Survey program and, until recently, in the Demographic and Health Survey program.

Information on population growth and fertility levels as it became available from censuses and surveys increased commitment to reduce population growth in all four countries. For example, Kenya became committed to this issue after the Kenya Fertility Survey demonstrated that the fertility level had reached as high as eight children per woman. Availability and presentation of technical information in simple form was one means by which the views of leaders were changed in Egypt, Kenya, and Mexico.

The Influence of International Agencies

International agencies influenced the evolution of population policies in the four countries of interest here. These agencies provided scholarly, technical, and financial inputs. The analytical work by Coale and Hoover (1958), for example, contributed to the ongoing debate in India and Mexico. A consultant team from the Population Council in 1963 provided the impetus for population debate in Kenya. And presentations of the implications of population growth on socioeconomic development, based on computer simulation models, contributed to changing the views of political leaders in Egypt and Kenya. Sponsoring the participation of professionals in international population conferences helped to bring some of the global concerns to domestic debates on population. The training of professionals in demography and population planning created indigenous capacity to address population matters in the four countries. This capacity provided the main ingredient for the acceptance of fertility-control ideals by the governments of developing countries (see Caldwell 1997).

International agencies have contributed financially to the implementation of family planning programs. This contribution has ranged from about 10 percent in India to over 50 percent in Egypt and 95 percent in Kenya. While the financial influence of international agencies has been minimal in India, technical experts have had a significant effect on the design of programs. The introduction of method-specific contraceptive targets in India has been alleged to be a contribution of the American management experts sent by the Ford Foundation in the 1960s. Some of these experts also helped the government to design the first social marketing program to increase the availability of condoms. The World Bank advisory team that visited India following the 1994 Cairo conference provided impetus to the program's change in course, by abandoning method-specific targets and moving toward a reproductive and child health approach (Measham and Heaver 1996).⁵

The Implications of International Conferences

There is little doubt that internal politics influenced deliberations at international population conferences, but the events that took place at the Bucharest, Mexico City, and Cairo conferences also had implications for domestic policies and their implementation.

At the 1974 World Population Conference held in Bucharest, developing-country delegates emphasized the role of development as "the best contraceptive." This message reflected an ongoing debate within academic circles and within countries about the importance of socioeconomic development for the reduction of population growth. Following this conference, the population field in general and a number of international organizations went through a period of re-examination. The content of population policies, however, did not change for many reasons, including: a lack of consensus in academic circles and in international forums about what to do differently to reduce fertility; a general lack of interest among development specialists in doing anything differently in their own fields because many programs, such as those aimed at improved education, can be justified on their own merits; and, above all, because of competition for scarce resources (see Stoeckel and Jain 1986). Advocates of family planning programs were concerned about the possibility of shifting resources allocated for such programs to general development. Moreover, the implementation arm of population policies—family planning programs—had no influence over the design of or the resources allocated to development and health programs. Finally, there was no bureaucratic mechanism to improve consistency between population policies and development policies.

The implementation strategies adopted by these four countries following the Bucharest conference varied. Egypt is perhaps the only country where emphasis on development was not matched by attention to provision of contraceptive services. In India, the implementation of population policy took an unfortunate turn toward the extensive use of contraceptive targets for providers, incentives and disincentives for providers and clients, and forced vasectomies. Policy in Mexico shifted from pronatalist to antinatalist.

The 1984 International Conference on Population, held in Mexico, reflected a consensus among developing countries about the importance of family planning programs in reducing population growth. The period following this conference was marked by a focus on the implementation of family planning programs in all four countries.

A so-called paradigm shift occurred at the 1994 Cairo conference (ICPD). This includes a shift in the goal of population policies from reducing population growth to enhancing individual wellbeing. A reduction in population growth in this interpretation becomes the intermediary objective, rather than an end in itself (for differing views on whether ICPD recommendations reflect a population policy, see Basu 1997; Caldwell 1997; Germaine 1997; and Sai 1997). Indeed, the overall intent of population policies in early stages of their evolution was to improve human wellbeing. However, over the years, the implementation of programs in many countries lost track of this intent and opted for interventions, such as quotas and incentives, that were not deemed to be consistent with individual wellbeing. In this sense, ICPD refocused the attention of policymakers and program managers on the original intent of reducing population growth and fertility.

This shift in the objective of population policy implies that programs intended to reduce population growth have to respect human rights and have to be just in and of themselves. This implies further that government signatories to the ICPD Programme of Action should reject those means to reduce population growth that do not respect human rights. At the program level, this rejection would include incentives, disincentives, targets, coercion, and compulsion.

Prerequisites for Effective Population Policies

Public policies that seek to effect behavioral change have not fared well in many developing countries. Sometimes this is due to the absence of a charismatic leader who can generate public support for unpopular policies, as happened in Egypt in the case of both the population policy and the economic reform policy. Sometimes it is due to inefficiencies in the bureaucratic structure that is responsible for implementing a policy. These inefficiencies are reflected in many ways: inadequate resources allocated to the implementation of a policy, poor quality and inadequate availability of services, and the setting of unrealistic goals, as happened in India in both the education and the population sectors. At times, difficulties in providing services to people spread over a large area may be genuine, as in the case of India where the rural population is spread over 600,000 villages. Above all, the relative performance of these policies reflects the degree of people's willingness to change their behavior, as demonstrated by the impressive performance of the education sector in contrast to the population sector in Kenya. Thus, in order for a policy to be effective, it has to be accepted voluntarily and widely by those affected by it or it has to be enforced through the government machinery.

Population policy related to fertility reduction is likely to be effective if a large majority of men and women want small families and the policy is implemented efficiently to make available the means of fertility regulation, including abortion. This is likely to happen irrespective of whether the private sector or the public sector provides the means and whether these means are provided through a family planning program or through a reproductive health program.

Two questions that need to be addressed with respect to population policies are: what is the role of a government in providing means of fertility regulation? and what is the role of a government in creating a desire to control fertility?

What is the role of the public sector in providing the means of fertility regulation to those who want them? One view is: none. Fertility declined in Western countries prior to the development of modern contraceptive methods and organized family planning programs; it can happen as well in developing countries. Even if services offering modern contraceptives are required, some argue that the private sector will fill the need, provided there is a strong desire to control fertility. This view may be valid in circumstances where market economies work efficiently. Since that is not the case in most developing countries, there is a need to provide these services through the public sector, thereby reducing the financial cost of fertility regulation for those clients who cannot afford to

avail themselves of private-sector services. The provision of contraceptive and abortion services within a reproductive health framework, moreover, would reduce morbidity associated with the efforts to avoid unwanted childbearing.

What should a government do to create a desire for smaller families beyond the provision of contraceptive and abortion services? There is no consensus on this issue, either on theoretical or on empirical grounds. Four options for government action under conditions of high-fertility norms are hinted at here: (1) do nothing special; (2) change reproductive goals through propaganda, motivation, and information; (3) enforce small family size through administrative and political pressure; and (4) change institutional and social conditions so that they become more conducive to having small families.

The first approach provided the basis for designing family planning programs in the early evolution of the population sector.⁶ The second approach was added later on, and has been used widely since. The third approach has been used in varying degree primarily in Asian countries, and the fourth approach has been rarely tried.

The first approach assumes that desired family size will decrease over time either due to the so-called diffusion process or due to general social and economic development. There is a controversy in academic circles about the relative importance of diffusion versus socioeconomic development in reducing fertility. But a resolution of the issue is important in this context only if a special role of the government is envisaged in creating demand for small families, either by accelerating the diffusion process or by altering the socioeconomic development policies. On the other hand, if either the diffusion process or socioeconomic development is assumed to reduce desired family size in due course, it can be argued that government efforts in the meantime should focus on helping those individuals who want to regulate their fertility. Satisfying the so-called unmet demand for contraception in turn also would have a spillover effect on the reproductive behavior of other women.

The second approach has been the purview of information-education-communication (IEC) activities. The evidence regarding their effectiveness in changing desired family size is weak and debatable (see Freedman 1997 for a recent review). The implementation of the third approach—labeled “duress” by McNicoll (1997)—and its effectiveness depend upon the degree of political conviction, the strength of the administrative machinery, and, above all, the type of political system. A government that cannot implement a compulsory vital registration system, for example, cannot be expected to implement a fertility-reduction policy based, say, on incentives and disincentives linked to the number of children a couple has. On the other hand, a government with the capacity to administer such a fertility-reduction policy would, perhaps, not need it (see Visaria and Jain 1976 for the articulation of a similar argument in the wake of the Emergency period in India). Moreover, according to the ICPD recommendations, the third approach is not justified and some elements of the second approach are also questionable.

The fourth approach would be consistent with ICPD recommendations, if special efforts to reduce desired family size include policies oriented to reduce gender disparities in health, education, and economic opportunities. It is not clear whether other policy interventions, such as compulsory education or a ban on child labor, would be consistent with the ICPD recommendations (see Basu 1997). Nevertheless, these policies fall within the purview of broad development policies. The implementation of these policies would require reorientation of the entire development sector and would therefore require a strong government commitment not only to the reduction of fertility but also to the issues of gender equality and to reducing other disparities. Admittedly, development policies do articulate the rationale of economic development generally in terms of enhancing gender equality and reducing poverty. However, actual progress toward these goals has varied greatly among and within countries. It is beyond the scope of this essay to speculate about the reasons for these variations.

While governments of all developing countries have unanimously adopted the Programme of Action, an actual shift at the policy level and especially at the program level has not been swift. Speculation on the fate of the recommendations contained in the ICPD Programme of Action is the focus of the volume's final chapter.

Notes

1. A reduction in the population growth rate is believed to improve a country's prospects for economic development, which in turn is believed to enhance a country's ability to improve the lives of its citizens. This belief, while not accepted universally, is based on the reasoning that a reduction in fertility reduces the size and proportion of the population in the 0 to 4 year age group and, therefore, reduces the demand made by the education and health services for government resources. Thus, with declining fertility, per capita availability of resources for education and health increases even in the absence of a real increase in the allocation of government resources for these services. Thus, a reduction in the population growth rate implicitly has been assumed to improve human wellbeing. However, the actual impact of a reduction in population growth on the improvement in human wellbeing depends upon the way education, health, and economic policies are formulated and implemented in a country.

2. There has been an unintended ben-

efit of the unusual course of demographic transition in India. The state of Kerala is deemed a success story. The mortality decline in Kerala, however, took place much earlier than that of India as a whole, and it preceded fertility decline in the state. Consequently, the annual population growth rate in Kerala peaked much earlier and remained higher than that of all-India during the period from 1901 to 1971. The population of India in 1991 would have been 1.085 billion instead of 846 million had the country followed the same trends in fertility and mortality since 1901 as the state of Kerala. This means that while the population policy in India has been deemed a failure, the size of the country in 1991 was 239 million people smaller than it would have been had the country followed the example of Kerala.

3. The education data for Egypt, India, and Kenya are taken from the Demographic and Health Surveys conducted in the early 1990s; the data for Mexico are taken from the 1990 census. It is assumed that the education distribution of women in the 45-49-

year age group in the early 1990s reflects their educational achievement when they were 15–19 years of age in the early 1960s.

4. We do not know whether the reduction in education achievement observed in Kenya is an artifact of data quality. The latest Demographic and Health Survey currently being conducted would provide further evidence on the trends in education achievement.

5. It is too early to say anything about the actual implementation of this new approach or its effectiveness in reducing fertility. Nevertheless, three points are worth noting: it focuses exclusively on service delivery; it justifies the shift in terms of it being more effective in reducing fertility, rather than as a desirable end in itself; and it does

not incorporate changes in other sectors of development that would be required to create conditions favorable for small families.

6. For example, the Taichung experiment in Taiwan was started in the early 1960s with the purpose of delivering contraceptive services and information to those who wanted them (Freedman and Takeshita 1969). The approach was criticized then from several standpoints. There was skepticism that efforts focused solely on satisfying individual desires might not solve the aggregate problem. Davis (1967) argued that population policies should include strategies to reduce people's desired family size by altering institutional arrangements (for recent articulation of similar reasoning see Pritchett 1994a; McNicoll 1997).

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Egypt's Population Policy: The Long March of State and Civil Society

The international debate on population policy has fostered divergent strategies, some promoting the single-minded provision of family planning services and others backing overall socioeconomic development as the best means for stabilizing population growth.¹ Formulated as such, the debate seems to be missing salient components. Rarely are questions asked about the efficacy of a national policy itself, regardless of the strategy adopted. What contributes to the government's overall competence in formulating and implementing public policies? What groups in society reinforce policy objectives and what others may act as "saboteurs"? The fortunes of a population policy may be no better or worse than those of other public policies in a given country at a given time. To examine these questions in more depth, this chapter reviews the Egyptian case.

Egypt's population policy experience represents an illuminating case study for the ongoing international debate, for Egypt has tried both sides of the argument, simultaneously and sequentially: both provision of family planning services and concerted socioeconomic development. The Egyptian case also sheds new light on some missing components of the debate: the efficacy of population policy choices and the ability of government to pursue any of its public policies amid an array of other civil forces and constraints. The heated media controversy in Egypt over the hosting of the United Nations International Conference on Population and Development (ICPD) in 1994 testifies to the fact that, more than 30 years after the country's first population policy was formulated, major constituencies in Egypt remained unconvinced that the basic principles of the national population policy were sound.

Egypt's physicians and social scientists had noted the country's population problem as early as the mid-1930s—in terms of a rapid population growth rate outstripping the country's capabilities to expand its resource base. Yet, it was not until the early 1960s that Egypt declared its first population objective, to slow the rate of population growth and speed up the rate of economic development. In the subsequent three decades, population growth has oscillated between 3.1 and 2.1 percent per annum, while economic growth has ranged from 0.0 to 8.0 percent. Between 1960 and 1994, Egypt's population more than doubled, from 26 million to 60 million. While the growth of real income per capita may have kept pace, financing Egypt's economic development has led to a heavy external and internal public debt, estimated in the early 1990s to be about \$40 billion. The per capita share of that debt equals the average annual income per capita—that is, about \$630. A persistent high rate of population growth is often cited as the main culprit, and consequently the population policy is judged to have fallen far short of its objectives.

This chapter examines Egypt's population policy over several decades to identify where, how, and why it may have succeeded or fallen short of its objectives. The framework for assessment takes into account distinctions between population policy goals (that is, fertility reduction, spatial redistribution, reduction in infant mortality, and so forth) and the way those goals are rationalized to the public (for example, poverty reduction, individual welfare, and societal development). The framework also takes into account that policy mechanisms (such as the promotion of family planning) may be accepted or rejected by various groups in the society for reasons other than those reflected in the official policy objectives. To better understand the complex elements contributing to policy performance, the study assesses the differing perspectives of relevant Egyptian actors. Most population studies focus on service providers and clients—for our purposes, government agencies and women (or couples). Both of these, however, are influenced by a multitude of intermediaries, including community leaders, civil associations, and traditional alliances whose pivotal role in population policy development and implementation has often been neglected.

While population policy in theory encompasses mortality, fertility, and migration, in Egypt the policy focus has been predominantly on fertility reduction (National Population Council 1993b). Population policy (like all public policies) is formulated at the upper levels of government. The middle and lower levels oversee its implementation by targeting families in the reproductive stage of their life cycle, with the objective of reducing births and achieving longer spacing between them. Whether or not persons at this level of government are strongly committed to the policy and whether or not the government has provided adequate institutional channels and inputs for its implementation are among the factors that need to be evaluated.

Such national-level variables are important, but micro-level factors bearing on individual men and women are even more critical. Their intimate decisions about fertility are made within families and a community of peers, neighbors,

and friends. Increasingly, and especially in Egypt's urban areas, formal and semi-formal networks have become powerful intermediaries in shaping, sifting, and sorting individual views on reproductive behavior. In other words, the government's messages and actions pass through many filters before individuals respond to them. Hence, the government's effectiveness in neutralizing or winning over those intermediaries will help determine the reproductive behavior of men and women. In this study, we refer to those layers of nongovernmental actors as "civil society." They include some obvious players, such as civic and religious leaders, and other less obvious groups such as politically mobilized professional unions.

Previous evaluations of Egypt's policy performance have not assessed the degree of concordance among members of various civil associations and protest groups such as the Islamic activists, or between those various groups and the government's population policy. This chapter attempts to bridge that gap by presenting the findings of a field study conducted in nine Egyptian governorates.

AN OVERVIEW AND HISTORY OF EGYPT'S POPULATION POLICY

A formal public policy should contain the following elements: clear formulation of objectives, allocation of resources, and institutional arrangements for implementation, monitoring, and evaluation. Depending on the country's system of governance, the emergence of a public policy may be preceded by a period during which the lobbying of a small number of actors triggers a national debate leading toward broad-based support for policy adoption. In other settings, the promulgation of the policy itself generates debate, awareness, and support.

The emergence of Egypt's formal population policy unfolded gradually over three decades, from the 1930s to the 1960s. It took two additional decades to mature into a full-fledged, nationally funded public policy in the 1980s.

The Rumblings of the 1930s and the Timid Encounters of the 1950s

In the 1930s, Abbas Ammar, a social geographer at Cairo University, and Wendel Cleland, a professor at the American University in Cairo,² sounded the first alarms over Egypt's population problem. By then it had become clear that the country was experiencing rapid demographic growth. Trend statistics were available, as Egypt had conducted four consecutive ten-year censuses since 1897. If estimates of the country's population by Napoleon's experts of the French Expedition a century earlier (1798–1802) were accurate at around 4 million, then Egypt more than doubled its population in 100 years—to about 9 million in 1917. By the time of Ammar's and Cleland's warnings, the country was already approaching a population of some 15 million. In 1937, a conference of Egyptian physicians called publicly for national programs to curb population growth.

Only a few nongovernmental organizations (NGOs) and small groups of Egyptian scholars and intellectuals took the warning seriously.³ Among their proposals were calls to reform the conditions of Egyptian peasants, some even

LANDMARKS IN THE DEVELOPMENT OF EGYPT'S POPULATION POLICY

- 1928 The first scholarly paper on Egypt's population is presented at the World Geographical Congress, Cambridge, UK, by Dr. Mohammed Awad Mohammed.
- 1929 "Analysis of Egypt's Population Estimates in the 19th Century" is published in *Égypte Contemporaine*, March.
- 1936 Abbas Ammar and Wendel Cleland independently publish studies warning about unchecked population growth in Egypt.
- 1937 The Egyptian Medical Association organizes a Conference on Population. The first Islamic pronouncement (*fatwa*) permitting family planning is made by Sheikh Abdel-Maguid Selim, Grand Mufti of Egypt and Rector of Al-Azhar.
- 1945 The Maadi Child Welfare Society offers Egypt's first contraceptive and infertility services.
- 1954 The Governmental Committee on Population Affairs is established.
- 1955 Eight experimental clinics are opened by NGOs to offer family planning services.
- 1961 The National Charter proclaimed by President Nasser endorses family planning as a national policy to slow population growth. The first organized effort at policy implementation is undertaken by an NGO, the Egyptian Family Planning Association.
- 1965 The Supreme Council of Family Planning (SCFP) is established by the government and chaired by the prime minister.
- 1973 The SCFP evolves into the Population and Family Planning Board (PFPB).
- 1974 A demand-driven Population and Development Program is inspired by the Bucharest World Population Conference.
- 1980 An influential NGO, Family of the Future, is established.
- 1984 A National Conference on Population is chaired by President Mubarak. The National Population Council is established, replacing the PFPB.
- 1985 The Copper-T IUD is introduced on a large scale.
- 1988 The Clinical Services Improvement Project is introduced by the Egyptian Family Planning Association.
- 1993 The Ministry of Population and Family Welfare is established.
- 1994 The International Conference on Population and Development is held in Cairo, recognizing Egypt's progress in addressing its population problem.
- 1996 The Ministry of Health and Population is created to signal the close relationship between reproductive health and family planning.

daring to suggest an agrarian reform scheme—a redistributive measure to reduce the flagrant concentration of land ownership. This signaled an early, if vague, awareness of a link between the population problem, poverty, and socioeconomic development.

These early rumblings did not result in a formal population policy, but they did lead the government to establish a special "Peasant Affairs Department" (*Maslahat*) in the mid-1930s, which quickly evolved into the Ministry of Social Affairs in 1939. That ministry eventually came to have considerable control over the activities of NGOs, a role it retains to the present day. Soon after, World War II and swelling nationalist aspirations pushed the population problem to the margins of Egypt's public debate until well into the 1950s.

Egypt's sociopolitical system changed in 1952 when a group of revolutionary officers, led by future president Nasser, established themselves at the helm of the government. Their first priority was to address Egypt's socioeconomic problems. In 1953, two Permanent Supreme Councils were established, one to promote production, the second to promote social services. A National Committee for Population Affairs (NCPA) was formed to address population issues, and its establishment ignited the continuing debate on the best approach for coping with rapid population increase. The majority opinion, backed by the revolutionary officers, was that equitable socioeconomic development was bound to curb population growth in time. The minority opinion held that Egypt should not wait until the fruits of such development exerted their impact on demographic trends, because the growth rate itself could derail economic growth (National Population Council 1993b).

Some observers at the time suspected that President Nasser, himself the father of five children, felt that a bigger population gave Egypt greater weight in Arab, Middle Eastern, and international affairs. Military strategists often equate population size with power, and some of Nasser's public statements seemed to substantiate this suspicion.⁴ However, Nasser would change his views on the matter several years later.

An Objective Without a Policy in the 1960s

In 1961, nine years after Nasser came to power, he articulated his general vision and proposed an agenda for the country in a document titled "The National Charter." It was widely representative of the views of all major social actors at the time. Of interest to us is an unequivocal statement asserting that "high growth rates represent the most dangerous obstacle that hinders efforts to raise the standard of living of the Egyptian people" (Department of Information 1961: 49). Since then, every Egyptian government has reiterated this assertion.

It took several years after the Charter was issued to operationalize the assertion in a concrete objective. In 1965, the Egyptian government declared its first population objective, namely "reducing the crude birth rate (CBR) by one per thousand per annum" (National Population Council 1993b: 13). It also declared its support for family planning efforts, pledging to prepare a network of

family planning service delivery outlets. However, because the government was preoccupied at the time with economic and military concerns, it invested little other than rhetoric in the effort. A Ministry of Health program initiated some services in 1966, complementing the health and community development activities of various NGOs.

After the 1967 military defeat in the third Arab–Israeli war, Egypt became even further mired in other concerns. Nevertheless, the mobilization of one million Egyptian soldiers along the Suez Canal for the following seven years helped to achieve the government's objective of slowing the rate of population growth. It was an achievement by default, however, and not the result of a policy.

A Policy Without Objectives in the 1970s

Shortly after the October 1973 war and the demobilization of troops, the first true national population policy was formulated, with a ten-year implementation plan (1973–82). Both the policy and the plan were couched in general terms. They emphasized the links between population growth and socioeconomic development, and reiterated the majority opinion of the NCPA of 20 years earlier. The policy took as an article of faith that “demand for family planning services hinges critically on the level and nature of development efforts” (National Population Council 1993b: 13). Such efforts would include expediting progress on several fronts before explicit demographic goals could be achieved, including an increased standard of living, mechanization of agriculture and industry, upgrading education, improving the status of women, extending coverage of social security programs, reducing infant and child mortality, adopting relevant information, education, and communication (IEC) programs, and upgrading family planning services.

This list of “desirables,” however commendable, got the population practitioners nowhere. In a policy re-articulation in 1975, four aspects of Egypt's population problem were clearly identified: rapid population growth, spatial maldistribution, a low level of socioeconomic development, and uneven age structure (National Population Council 1993b: 13–14). Although a definite advance over previous government documents, the 1975 National Population Policy still lacked resource commitments equal to the magnitude of the task (National Population Council 1993b: 13).

A Policy with Clear Objectives in the 1980s

A second national population policy was issued by the Egyptian government in 1980, titled “National Strategy Framework for Population, Human Resource Development, and the Family Planning Program” (National Population Council 1993b: 14). In this and related documents, we see for the first time clear objectives and targets, along with definite measures for their achievement according to a specified timetable. One target was to reduce the crude birth rate by 20 per 1,000 by the year 2000, from a starting point of 40.9 per 1,000 in 1980.

A mark of this new commitment was the National Conference on Population in 1984 and the establishment of the National Population Council (NPC)

shortly after to replace a succession of lower-level governmental bodies. President Hosni Mubarak himself headed the NPC board in its early years. In 1986, the NPC formulated the third national population plan. It was far more advanced than previous plans in the clarity of its targets and in its programmatic feasibility. Many of the objectives of the third plan were achieved on time or even earlier.

Reflecting on the lessons learned from more than three decades, the plan put greater emphasis on the "free choice" of citizens to regulate their family size, and on their right to migrate internally or externally. International principles of sound development planning are reflected in the plan document—grassroots participation, empowerment of women, education for all, environmental concerns, and a decisive role for NGOs. Equally significant is that the third population plan was integrated in the National Five-Year Plan of 1987/88–1991/92, the first time this had occurred. This ensured, among other things, a parliamentary debate before the population plan was enacted into law, and the specific allocation of budgetary resources for its implementation.

Consolidating Policy and Implementation in the 1990s

In Egypt, power is highly centralized and concentrated in the executive branch of the government. Egyptians have learned to take their cues about the relative importance of policies, issues, events, and people from various political symbols and terminology. The designation of a governmental organization as a "committee," a "commission," a "council," or a "ministry," for example, carries with it progressive levels of prestige and importance. Thus, it is significant that on 14 October 1993 a new cabinet position, the Minister of State for Population and Family Welfare, was created. Dr. Maher Mahran, who had been Secretary General of the National Population Council since 1986, was appointed Minister. In early 1996 a consolidated Ministry of Health and Population was created under the leadership of Dr. Ismail Sallam. This evolving stature symbolizes the increasing importance of population as a priority of the Egyptian government.

Perhaps of even greater policy importance was the presidential decree naming the new prime minister, also in October 1993. President Mubarak charged the new government with the task of addressing seven political objectives, among them—for the first time ever—the population problem. Thus, both symbolically and substantively—and at the highest government level—population has become a paramount policy issue in the 1990s. Why did both Nasser and Mubarak come to believe, well into their presidencies, that population issues deserved greater attention? In Nasser's case, it appears that radical fervor and a single-minded belief in his economic reforms became tempered over time by the intractable nature of poverty in the country. Similarly, Mubarak appears to have concluded that his policies of economic liberalization alone would not lift Egypt's fortunes. Both men were faced with the stark demographic reality that population growth was swallowing up gains on the socioeconomic front. Once having made the commitment, they turned their attention to articulating and implementing the policy.

POPULATION POLICY IMPLEMENTATION

Since the mid-1960s, a national body (currently the National Population Council) has been in charge of coordinating Egypt's population policy. The Ministry of Health and Population, the State Information Service, and the Ministry of Social Affairs through the work of NGOs have been major partners in implementing this policy, with other government bodies involved to a lesser extent.

As already noted, Egypt's population policy entails, in theory, more than family planning. In reality, however, the distribution of contraceptives in family planning clinics has been the main concern of most implementing groups. This narrow focus is partly due to international agency influence and partly to a lack of confidence in other measures. In addition, other sectoral programs, such as education or investment in new communities, are beyond the direct control of coordinating agencies as the NPC. Thus, by the 1980s the service delivery side of population strategies had prevailed over other strategies such as redistributing wealth or raising women's status. Consequently, the following account focuses mainly on the evaluation of national family planning efforts in recent years.

Family Planning Services

Family planning service delivery is provided by the Ministry of Health and Population, community-based NGOs under the supervision of the Ministry of Social Affairs, pharmacies, and private clinics. All together, there are some 16,000 public and NGO facilities working in family planning-related activities, along with many of Egypt's 100,000 private physicians and more than 20,000 pharmacies. The relative share of these various service delivery points tilts toward the public sector, which was responsible for distributing approximately 36 percent of all methods used in 1995 in comparison to 24 percent in 1988 (National Population Council, EDHS 1988 and 1996).

Information, Education, and Communication

With the major media of mass communication still government-controlled, the Ministry of Information has increasingly deployed its departments to promote the population policy. Television advertisements, messages, and dramatic serials often use popular actors and actresses to promote family planning. Radio has been mobilized in a similar manner. An unofficial account estimates the time devoted to media propagation of family planning messages to have increased sevenfold between 1980 and 1990 (National Population Council 1993b: 43). According to Egypt's 1992 Demographic and Health Survey (EDHS), over 70 percent of Egyptian women acquired their knowledge about family planning from television.

Since the early 1980s, the Ministry of Education has begun teaching population-related issues, including family planning, in home economics and science classes at girls' secondary schools. In the mid-1980s, similar teaching materials were introduced in boys' schools. In the early 1990s more subtle messages on the values of a smaller family have been interspersed in other

teaching materials for Arabic language, civics, and social science classes. But the Ministry's more indirect but equally important role lies in combating illiteracy, especially among women and marginal groups in rural areas. Aside from being a worthwhile objective in its own right, literacy is a proven means to more effective service utilization, and to changes in the values and behavior related to reproduction.

Other Population-Related Development Activities

The manner in which Egypt's population policy has been formulated since the 1960s makes nearly all government organizations responsible to some degree for its implementation. For example, the objective of population redistribution is the responsibility of five ministries: the Ministry of Reconstruction and New Settlements, the Ministry of Defense, the Ministry of Tourism, the Ministry of Land Reclamation, and the Ministry of Industry. Each of those has to generate plans, programs, projects, and activities that will lure people away from the overcrowded Nile Valley and Delta governorates toward the new communities in the desert and in border governorates (Red Sea, Sinai, Matrouh, and New Valley). Likewise, the Ministry of Manpower and Training is in charge of reducing unemployment among men and of increasing paid employment for women, through targeted training and retraining programs. A main task of these various ministries, therefore, is to contribute to the policy objective of improving the socioeconomic status of Egyptians.

In short, the implementation of Egypt's population policy is, at least in theory, multilevel and multisectoral. This plethora of agencies and activities makes it difficult to determine where true accountability rests within the system. The problem has been compounded by recent efforts to decentralize responsibility for population targets. Thus, a new layer of actors—governors and local officials—is added to the picture.

POPULATION POLICY PERFORMANCE

In this section, we evaluate the success of Egypt's population policy in terms of several indicators, including fertility trends, nuptiality, prevalence of family planning, and migration.

Fertility Trends

Egypt's success in achieving its first population policy objective—the reduction of growth rates—can be inferred from the steadily declining fertility rate. Egypt has maintained fairly good vital statistics since 1912. Until the 1930s, the crude birth rate (CBR) hovered around 50 per 1,000 population. It began a slow but steady decline in the early 1940s and dropped to a little above 40 per 1,000 in 1960, around the time when the government population policy was initiated. Despite slight fluctuations, the overall downward trend continued at a slow pace and reached 36.6 per 1,000 in 1988. Then the pace of decline became markedly faster (see Table 2.1), with the CBR dropping to 31.0 per 1,000 in 1991 and to 28.6 in 1995.

Table 2.1 Egypt's population: Size and vital rates, 1950–95

Year	Population (millions)	Birth rate (per 1,000)	Death rate (per 1,000)	Growth rate (per 1,000)	Total fertility rate	Infant mortality rate ^a
1950 ^b	20.33	45.1	17.9	27.2	6.56	200
1952 ^b	21.44	45.2	17.8	27.4	6.56	
1960 ^c	25.96	42.9	16.9	26.0	7.09	150
1966 ^c	30.08	41.2	15.9	25.3	6.53	
1970 ^b	32.34	36.1	15.1	21.0 ^d	5.53	115
1976 ^c	36.63	38.0	11.7	26.3 ^d	5.27	
1980 ^b	42.13	40.9	10.4	30.5	5.20	85
1986 ^c	49.86	38.7	9.2	29.5	4.90	
1987 ^b	51.35	37.4	9.1	28.3	4.38	
1988 ^b	52.83	36.6	8.1	28.5	4.38	
1989 ^b	54.21	32.2	7.7	24.5	4.38	
1990 ^c	55.54 ^b	32.5	7.5	25.0	4.38	65
1991 ^b	56.90 ^b	31.0	7.6	23.4	3.90	
1992 ^e	58.19 ^b	29.2	7.4	21.8	3.90	43
1995 ^f	58.98	28.6	6.8	21.8	3.60	

^a National Population Council (1994).

^b Central Agency for Public Mobilization and Statistics (CAPMAS), estimates based on *Civil Register*.

^c Census figures.

^d The 1970 and 1976 official figures are widely suspected of inaccuracy; the US National Academy of Sciences estimates give growth rate figures of 21.8 per 1,000 (instead of 21.0) for 1970 and 26.9 per 1,000 for 1976 (instead of 26.3). With either set of figures, however, the trend is in the same direction.

^e United Nations (1991).

^f National Population Council (1996).

Assuming that the figures for the last 40 years are accurate, it would seem that the reduction of the CBR is due to structural, not to transient, factors. Should the trend continue at the same or even at a slower pace for the rest of the 1990s, it could become irreversible. The only caveat here is that Egypt had witnessed a sharp reversal in the direction of its annual CBR between 1960 and 1980, dropping from 42.9 per 1,000 in 1960 to 36.1 per 1,000 in 1970, and then rising again to a high of 40.9 per 1,000 in 1980.

The forces underlying the declining growth rate, however, are more clearly indicated by the total fertility rate (TFR)—the number of children a woman would have during her reproductive life from 15 to 49 years of age. Unlike the CBR, the TFR has not fluctuated. Instead, there has been a steady decline from 7.09 children born to females aged 15–49 in 1960 to 3.9 in 1990–92.

Nuptiality

An important means of reducing population growth is to delay the onset of family formation. The timing of marriage, referred to as nuptiality, has changed significantly in Egypt in recent years, primarily due to delayed age at marriage. One indicator of this change is the crude marriage rate (CMR)—the number of marriages per 1,000 population. In 1950, the Egyptian CMR was about 11.0 per 1,000. It declined to 8.3 in 1992, despite a brief upsurge in the late 1970s and early 1980s (the post-1973 “war marriage” boom).

Added substantiation for the trend toward delayed age at marriage, especially for women, comes from the census data for 1960 and 1986. During that quarter of a century the number of women 16 years of age and older who were never-married rose from 12.0 per 1,000 to 20.0 per 1,000. Delayed age at marriage means a shorter reproductive period and a longer span between each generation, thus reducing population “momentum.” The average age of women at first marriage increased from 18.3 to 20.7 years between the early 1970s and the mid-1990s. Much of the delay in marriage age was attributable to increased female education or to financial difficulties among urban couples. It is disconcerting to note that roughly 20 percent of Egyptian women, largely concentrated in rural areas, still marry below the legal minimum age of 16.

Family Planning

Reliable national family planning data exist only since the 1980s, with the comprehensive Demographic and Health Surveys conducted in 1988, 1992, and 1995 together with a number of other surveys commissioned by the NPC.

These data indicate a steady increase in the use of contraceptives. The contraceptive prevalence rate (CPR)—the percentage of currently married women reporting use of any contraceptive method—has risen from about 24 percent in 1980 to 48 percent in 1995 (see Table 2.2). There is a marked regional variation in CPR. For example, in 1995, CPR in urban governorates averaged 58 percent as compared with about 55 percent in Lower Egypt and only 32 percent in Upper Egypt. The biggest net increase between 1988 and 1995 was in Lower Egypt (14 percentage points), followed by Upper Egypt (10 percentage points), and the urban governorates (2 percentage points). Since rural areas of Upper Egypt account for 24 percent of the country’s population, its CPR needs to be increased from its current level to the level prevalent in other governorates, in order for the overall CPR to rise significantly.

The media and educational blitz informing Egyptians about the methods and desirability of family planning must be credited with much of the progress noted in the 1980s and 1990s. According to the 1995 DHS, nearly 100 percent of married women know about contraception, and some 93 percent know of a source for information and/or services. However, only about two-thirds of married women have ever used contraceptives, and less than one-half are cur-

Table 2.2 Percentage of currently married women using contraceptives in Egypt, by method (1980, 1988, 1992, 1995)

Method used	EFS, 1980	1988 EDHS	1992 EDHS	1995 EDHS
Any method	24.2	37.8	47.1	47.9
Any modern method*	22.8	33.5	44.8	45.5
Pill	16.6	15.3	12.9	10.4
IUD	4.1	15.8	27.9	30.0
Injectables	—	—	—	2.4

*Modern contraceptives include the pill, IUD, diaphragm, condom, and injectables.
Source: 1980 EFS (unpublished), quoted in 1995 EDHS; 1988, 1992, and 1995 Egypt Demographic and Health Surveys.

rent users. In the gap between awareness and practice lies the major challenge for Egypt's policymakers and implementers. For example, according to the 1995 EDHS, while 64 percent of married women wanted no more children and another 15 percent wanted to space their next child for at least two years, only 48 percent were using contraception. Trends for the country as a whole seem to indicate a decline in unmet need for contraception from 20 percent in 1992 to 16 percent in 1995. In conclusion, Egypt's official policy to slow the population growth rate through reduction of fertility seems to be taking hold, although considerably more gains are possible by reducing unmet need further.

Migration

In 1974, Egypt's external migration laws were loosened to create an "open door." Since then, large-scale migration flows out of Egypt have occurred, primarily by males to the oil-rich Arab Gulf states. In the late 1980s, the number of Egyptians working abroad (that is, temporary migrants) was estimated to be around 2.5 million.⁵ Migration opportunities are diminishing, however, and it is expected that a majority of the Egyptians abroad will return home. As a matter of fact, as many as 25 percent of migrants to the Gulf area were forced to return en masse from Kuwait and Iraq during the 1990–91 Gulf crisis. While conclusive evidence is lacking, one can speculate that large-scale male migration throughout the 1980s had a fertility-depressing effect. Rapid repatriation could possibly result in a temporary fertility "bulge."

EVALUATING POPULATION POLICY

In the early 1960s when Egypt initiated its population policy, the country contained 26 million inhabitants and the annual rate of growth was 2.8 percent. By 1987 the population was 50.5 million and the annual rate of growth was still 2.8 percent. These two points of comparison alone might suggest that Egypt's population policy had failed dismally in achieving its primary objective of reduced growth. But as the previous analysis showed, Egypt's growth rates fluctuated, and the annual growth rate did decline from 2.8 to as low as 2.1 percent in the ten-year period 1961–70. The rate rose again, from the 1970s to the mid-1980s, to reach an all-time high of 3.1 percent in 1980. In the following 12-year period, 1980–92, Egypt managed another sharp reduction of the annual rate from 3.1 to 2.2 percent (see Table 2.1).

Controlling the Population Growth Rate

Thus, we begin our evaluation of Egypt's population policy by noting that Egypt has not only contained population growth, but has done so rapidly and forcefully. Had Egypt been able to maintain its 1970 rate of growth of 2.1 percent over the entire interval from 1960 to 1994, its population in 1994 would have been only 50 million—some 10 million less than its actual size of 60 million. On the other hand, had Egypt maintained its substantially higher 1960 growth rate of 2.8 percent over the entire interval, its population could have

reached 65 million by 1994, or 5 million more than its actual size. With its actual policy performance, Egypt reduced its population by only one-third of what it could have achieved had it maintained the 2.1 percent growth rate since 1970. As a crude measure of success, Egypt thus achieved 33 percent of its primary population policy objective.

Much of this success was achieved in the first decade and in the most recent five years (1989–94) of the policy. Between those two periods there were some 20 years of zigzagging and muddling through. Though different in many ways, the two periods of success had one thing in common: the existence of a comprehensive Five-Year National Plan for socioeconomic development. These two periods together were approximately one-half of the time span of Egypt's population policy. Gauged by Egypt's steadily declining total fertility rate, the country has done as well as most other developing countries with similar goals during the same period (from the 1960s to the 1990s). The fact that Egypt's population growth rate has not declined further is due to an even faster rate of mortality reduction (from 16.9 per 1,000 population in 1960 to 7.4 per 1,000 in 1992). Thus, while total fertility declined by 45 percent, mortality declined by 56 percent during the same period (1960–92).

Spatial Redistribution

A second objective of the population policy, a more balanced spatial distribution, was introduced in the mid-1970s. On this objective, there is yet to be any marked success. Between 1976 and 1986, the governorates that were highly dense grew even more so. Of the four border governorates—New Valley, Matrouh, Red Sea, and Sinai—that were not densely populated, only Sinai experienced a substantial increase in its population density, from 0.2 to 3.3 persons per square kilometer. But even here, a caveat is in order. Until 1976 much of Sinai was still occupied by Israel; hence, most of its native population were either refugees in the rest of Egypt or were under Israeli occupation, and not counted. In New Valley, Matrouh, and Red Sea, the density per square kilometer is less than one person, compared with Cairo's approximately 24,000, or the country's overall density of 48.

According to both the Population Plan and the National Five-Year Plan that began in 1987, Egypt was to build some 20 new cities, in desert and border governorates. These new settlements were to reach 200,000–350,000 inhabitants each, thus absorbing some 5.5 million of the expected 7 million population increase during those five years (National Population Council 1993b: 29). An estimated 5 billion Egyptian pounds (L.E.)—equivalent to US\$1.5 billion—was earmarked toward fulfilling this objective. Most of this investment was spent on infrastructure and housing. However, these communities, along with older ones built between 1975 and 1982 (Tenth of Ramadan, Sadat, and Sixth of October cities) have attracted only about 7 percent of the targeted population, or 350,000 out of the 5 million targeted.

Noteworthy here is that besides the L.E. 5 billion invested by the government, at least as much was invested by the private sector. Part of the private

investment went to high-technology industries in the new cities. Being capital-intensive, these industries did not generate as many jobs as Egypt's planners had counted on. Many of the new cities are also so close to old urban centers that workers and employees prefer to commute from their homes rather than take permanent residence in the new cities.

Other public and private investments went toward new tourist and vacation resorts along the coasts of the Mediterranean, the Red Sea, and the Sinai. The Northern coast highway between Alexandria and Matrouh illustrates dramatically how a sound policy objective gets distorted or abused. One side of the road, overlooking the sea, is highly developed with luxury vacation compounds that are used for a few months every year by their well-to-do owners. The other side of the road remains undeveloped. People living on the left side of the road to Matrouh, mostly Bedouin, still lead much the same lives as their ancestors.

Socioeconomic Development

A third major policy objective was to enhance the socioeconomic characteristics of Egypt's population. Health has seen a marked improvement, as indexed by the infant mortality rate (IMR), which fell sharply from 150 to about 65 per 1,000 live births between 1960 and 1990 (see Table 2.1). Official figures indicate a further reduction to 43 per 1,000 in 1992 (IDSC 1993: 11). Behind this substantial improvement is a growing public health system. In 1994 it comprised more than 100,000 physicians, 108,000 hospital beds, 3,500 primary health care units, and 20,000 pharmacies.⁶

On other indicators of socioeconomic development, Egypt has also made progress. The number of persons who have access to safe drinking water rose from 50 to 90 percent of the population between 1960 and 1990. During the same period, Egyptians improved their calorie intake from 90 to 127 percent of the minimum daily requirements recommended by the World Health Organization. Adult literacy has risen from 30 to 48 percent, while primary and secondary school enrollment has risen from 55 to 89 percent. University enrollment among men grew at an average rate of 4.6 percent annually during the period 1960–90; the rate for women over the same period was 5.2 percent. Weighted purchasing power—the per capita share of the gross domestic product—rose from \$500 to \$1,934, nearly fourfold in three decades (UNDP 1992: 128, table 4).

Such noticeable progress has to be evaluated in comparative terms. How does Egypt measure up against other countries with similar profiles? The 1992 United Nations Development Program (UNDP) *Human Development Report* provides such comparisons based on the indicators discussed above. Egypt ranks 110th among 160 countries, and is classified as “low” on the Human Development Scale. For example, while in 1960 Egypt surpassed countries such as Morocco and India, by 1990 it had fallen behind Morocco, which ranked 106th. While still behind, India (ranked 121st) caught up with Egypt in terms of life expectancy and adult literacy rates (UNDP 1992: 128, table 4). Based on the World Bank's economic indicators, between 1987 and 1993 Egypt slipped from

the "low middle" economies category to the "low" economies category. Egypt's annual economic growth rate dropped from an average of 8 percent in the 1970s to 2 percent throughout most of the 1980s.⁷ Estimates for the mid-1990s range between 3 and 4 percent.

POLICY PERFORMANCE IN CONTEXT

Over the past three decades, Egypt's population policy could be judged modestly successful in achieving its objectives of reducing the population growth rate and improving socioeconomic status, and only marginally or not at all successful in the third objective of spatial redistribution. But in order to place these evaluations of success or failure in perspective, one should ask whether Egypt has achieved any better overall performance in other policy spheres. The mixed record on population policy, in fact, is not unique; other public policies in Egypt have suffered the same shortcomings.

A case in point is economic reform policy. Launched in 1974, under the name of *Infitah* or the Open Door Economic Policy, it aimed at liberalizing the Egyptian economy from a state command economy to a free-market economy. Timidity, bureaucratic resistance, and half-hearted measures resulted in the rapid accumulation of external debts (from less than \$5 billion in 1974 to about \$50 billion in 1990) and growing budgetary deficits (from less than 10 percent of GNP to over 25 percent). Despite forceful recommendations by a National Economic Conference convened by President Mubarak in 1982 for stabilization and structural adjustment, public opinion was slow to be won over, and old systems were hard to dislodge; not until May 1991 were any of those recommendations enacted into policy. Momentum for reform increased after January 1996 with the appointment of a new Prime Minister.

While it is too early to judge the outcome of this economic reform and structural adjustment policy (ERSAP), the process of its formulation and implementation bears a marked resemblance to that of the population policy. Both policies required the public to adopt new and unpopular behaviors (reducing family size and economic belt-tightening). Both involved a challenge to firmly held values—fertility on the one hand and socialist/welfare state benefits on the other. Though more recently initiated, the economic reform policy seems to have gone through a similar process of hurdles and zigzags, and to have produced mixed results. It took some 18 years for the declared objectives of the economic reform to be operationalized into a coherent public policy. Some of the reasons behind this lackluster policy performance are examined below.

The Long Incubation Period Before Structural Adjustment

Since 1952, Egypt has followed a quasi-socialist command economy. The country's disastrous defeat at the hands of Israel in 1967 compelled Egyptians to reassess the performance of the government, society, and the economy. The result of this published national review, announced by President Nasser, be-

came known as "The March 28, 1968 Declaration." For the first time in 16 years, the socialist command economy was criticized and an effort at economic reform was pledged.

The March 1968 pledge would not be made concrete until six years later, however, in February 1974, when the Open Door Economic Policy was issued by Nasser's successor. President Anwar Sadat carefully drafted the policy, "not to undo Egypt's socialism, but to invigorate the public sector through competition; to attract Arab and foreign capital, and modern technology and management systems." The law provided for setting up joint-venture companies with Egyptian partnerships of no less than 51 percent. Many presidential decrees followed to detail the incentives for potential investors. Three years after its implementation, in January 1977, Egypt witnessed the worst food riots in its modern history. The army was called on to quell the riots sparked by increased bread prices, and many of the economic measures were retracted to calm the public (Ibrahim 1993: 4–5). External debt rose from \$1.5 billion to \$29 billion during Sadat's presidency (1970–81).

Shortly after taking office, President Hosni Mubarak convened a National Economic Conference, in February 1982, to review the situation. Extensive policy recommendations were issued for forceful economic reform and structural adjustment. The recommendations were hailed at the time by Egypt's creditors and international financial institutions, including the International Monetary Fund and the World Bank. However, the Mubarak regime remained reluctant to begin implementation. By the time an agreement was officially signed with the IMF and the World Bank, in May 1991, the debt had jumped from \$29 billion to \$55 billion.

Reform by Stealth

Ultimately, policy changes require political choices by decisionmakers who operate in the context of maintaining a domestic power balance. The actors to be persuaded in the ERSAP process have included a small but strategically located group of leaders from the private sector. Backed by the international financial community, these leaders were eager for reform. On the other hand, organized labor, managers from the public sector, leftist opposition parties, and Islamic activists vehemently opposed ERSAP. These groups were a significant threat to the policy because of their capacity to manipulate public opinion. Recognizing the inevitable need to implement ERSAP, the Egyptian government resorted to a practice that economists have dubbed "reform by stealth." Subsidies on certain basic goods and services are maintained, but the subsidized items themselves gradually disappear and are replaced by slightly modified and costlier items.

Mixed Results

As with the population policy, Egypt's "reform by stealth" produced some immediate results. Within the first three years of ERSAP, Egypt managed to stabilize its currency, reduce public expenditure, and lower the annual budget

deficit from about 25 percent to 7 percent. But beyond these initial successes, ERSAP has faltered. The rest of the package—for example, privatization—could not be carried out “by stealth.” Meanwhile, the first four years of ERSAP (1991–94) produced an unprecedented wave of politically motivated violence, mainly between Islamic activists and government security forces. While there may be no direct connection with ERSAP, the fact remains that violence has been concentrated in the country's most socioeconomically depressed areas. More-direct evidence of the troubled nature of ERSAP is the rising expressions of labor unrest—growing from ten incidents in 1990 to 183 in 1993. The two types of unrest have added to the government's reluctance to press forward with its reforms (Ibrahim 1995: 33–34).

The Capacity to Govern

A number of public policies that require popular support and behavioral change have not fared well in Egypt. From the inception of an idea to its implementation by the government often takes many years—30 years in the case of population policy, nearly 25 years in the case of economic reform. During this long stretch, the problem that the public policy is meant to address invariably worsens, requiring more drastic measures than would have been the case with an early start. Egypt's population more than doubled during the “hesitation period,” 1932–62. The country's external debts grew several times through periods of hesitation: in all, the debt rose from \$0.9 billion in 1968 to \$55 billion in 1991.

Part of the hesitation in implementing both policies was due to the government's fear of angry popular reactions to public policy measures. Such reactions, however, are not inevitable if respected leadership is present or if a credible participatory process is included in the formulation of public policy. For much of Egypt's modern history, the two conditions were rare. The success of Egypt's population policy during its first decade, 1960–70, was largely due to the commitment, albeit late, of a charismatic leader—President Nasser. In the absence of a charismatic leader, broad-based consensus on public policy has been hard to generate. The alternative is to rely on bureaucratic efficiency. In fact, much of the recent success of Egypt's population policy derives from improved efficiency in providing services for contraceptives the public now seeks.

EVALUATING THE MAJOR POLICY ACTORS

To better understand the dynamics underlying official policies, we conducted a survey of 696 individuals who are “stakeholders” in family planning programs and fertility reduction. The sample included senior national decision-makers, top and middle executives on the government level, family planning service providers, local community leaders, and women aged 15–49. The sub-sample of women was drawn from current clients at sampled family planning clinics and one or more of their female neighbors. Husbands, who have received little attention in the national population policy, were not included in the survey.

Communities included in this survey were purposely selected from low-income urban neighborhoods in the capitals of nine governorates, as well as from villages in nearby rural areas. The fact that this was a relatively small sample suggests that the findings from this survey should be seen as indicative and informative, rather than as representative of Egypt as a whole. To set the stage for our discussion of the survey results, we first examine the views on population of three successive Egyptian presidents.

The Views of Three Presidents

President Gamal Abdel Nasser (1952–70) held office for nearly ten years before officially recognizing the serious impact of Egypt's rapid population growth. The issue of population growth was addressed in the National Charter only in 1961. President Anwar Sadat (1970–81) paid little attention to the problem. He might even be seen as a negative influence, having arranged the marriage of one of his daughters before the legal age of 16. President Hosni Mubarak (1981–present) was in office for three years before paying serious attention to population issues. He subsequently agreed to chair the newly created National Population Council in its first three years. His interest seemed to wane in the late 1980s when he relegated this chairmanship to the prime minister, who convened the NPC Executive Board only once. In recent years, however, President Mubarak has taken a direct and renewed interest in the issue. This political commitment culminated in the winning bid to host the 1994 United Nations International Conference on Population and Development.

According to a close presidential aide, Mubarak began taking renewed interest in population issues in 1991. This informant attributed the change to several factors: the implementation of the International Monetary Fund (IMF) agreement for economic reform in the spring of 1991; the repeated emphasis given to population issues by high-level foreign visitors and Western aid donors; and, somewhat later, the approaching International Conference on Population and Development (with early indication that several heads of state would attend).

However, in contrast to his response to pressing economic and political issues, Mubarak did not devote an entire public speech to the population issue until September 1994. Prior to that, population was typically mentioned in the context of broader policy statements.⁸ Furthermore, the president's perception of the issue was narrowly focused on family planning, which he thought could best be handled by technocrats, especially physicians.

In late 1993 and early 1994, Mubarak began making proclamations about a "national strategic project" to develop and settle the Sinai and Red Sea governorates. This speech and others marked a growing commitment to the broad issue of population and development. Mubarak was bestowed the UN Population Award in June 1994.⁹ Shortly afterward, he defended Egypt's hosting of the ICPD against harsh domestic criticism. These events put Mubarak irreversibly and forcefully on a proactive course with respect to government population policy.¹⁰

The Views of Cabinet-Level Executives

For this study, 22 cabinet-level executives—18 ministers and 4 governors—were interviewed in 1993.¹¹ The interview started by asking about Egypt's major problems and/or challenges at present and in the near future. No specific mention was made of the population issue by the interviewer, who is a former cabinet-level official himself.

The number of specific problems mentioned by each executive ranged between 5 and 14. As shown in Table 2.3, only 4 out of the 22 top executives (18 percent) spontaneously mentioned the population question on their list of major problems and challenges. None of the four listed it in first or second place. The executive who produced the longest list, 14 problems, mentioned the population problem as number 13. Problems that had primacy, or were more frequently mentioned, included economic, political, social, and religious issues. Extremism and terrorism were also high on the lists, as were government inefficiency, lack of coordination, and shortage of government resources.

Aside from the four respondents who mentioned population spontaneously, the interviewer probed the others as to whether they perceived population as a problem. Out of 18, only 6 conceded that it was; another 8 thought overall development would take care of it; and 4 said high population growth is used merely as an excuse for other government failures.

These testimonies were unexpected, given that Egypt's current population plan has assigned specific roles to many of the ministries over which these cabinet executives preside. The Five-Year Plan specifically mentions at least nine ministries responsible for programs and activities bearing on the three policy objectives. All pertinent ministers (current or former) were among our sample of top executives.

The weak commitment to the government's population policy by a majority of high-level Egyptian decisionmakers may help to explain why so few of its objectives have been achieved. Even those who mentioned the population problem on their own or conceded its existence felt no direct responsibility for

Table 2.3 The population problem as perceived by Egypt's relevant actors

Category	Percentage of all respondents who		
	Spontaneously mentioned it as a problem	Agreed it is a problem after probing	Denied it is a problem
Cabinet-level executives (n=22)	18.2	27.3	54.5
Middle executives (n=45)	24.4	26.7	48.9
Field practitioners (n=54)	40.7	11.1	48.2
Physicians (n=36)	25.0	8.3	66.7
Social workers (n=18)	72.2	16.7	11.1
Community leaders (n=72)	34.7	19.5	45.8
Religious (n=36)	11.1	8.3	80.6
Civic (n=36)	58.3	30.6	11.1

Source: Ibn Khaldoun Survey data, 1993.

policy implementation. Their view was that responsibility lay solely with the National Population Council, the Ministry of Health, and the Ministry of Social Affairs.

The Views of Middle Executives

Forty-five mid-level technical executives were interviewed in nine governorates, each having direct responsibility for some aspect of population policy implementation. In each governorate, the directors general of Health, Social Affairs, Education, Information, and the senior representative of the National Population Council were included. Interviewers again asked a general question about Egypt's major problems, followed by a question on the population issue and respondents' views on the effectiveness of various societal actors in addressing the population problem.

Only 11 executives out of 45 (24 percent), including 7 NPC senior representatives, noted the population problem on their lists. To the interviewer's surprise, when she specifically introduced the population issue to an NPC representative in an Upper Egyptian governorate, the representative still would not consider it a problem. When told in effect that population was the *raison d'être* of his work, he responded that "it is just a job." Similarly, the director of health in a Delta governorate not only failed to mention population among Egypt's major problems, but she adamantly denied the importance of population size and growth, seeing spatial distribution as the only problem. When the middle executives were probed about population, 12 agreed it was a problem, bringing the total to 23 (51 percent).

Among the 49 percent of respondents at this technical level who did not mention population on their problem list, the most frequently mentioned issues, in order, were (1) unemployment, (2) absence of democracy, (3) terrorism, (4) poor public educational system, (5) backwardness of women, (6) corruption in high circles, (7) the growing gap between government and the people, (8) weak sense of belonging among people, especially youth, (9) poverty, (10) governmental neglect of Upper Egypt and urban slum areas, (11) weakness of social and religious values, (12) loss of credibility and confidence in the government and its media.

The research team interviewing this level of respondents concluded that a majority of leading government technocrats, in all nine governorates, were neutral or nonsupportive of the population policy, and that some were in fact resistant to it. They might comply with directives from their respective ministries in Cairo, but without really supporting the policy. As with cabinet-level executives, it is expected that the growing presidential commitment and public awareness post-ICPD will lead middle-level executives to display more support for the government's population policy.

The Views of Field Practitioners

The next level of public workers interviewed was physicians and social workers in local family planning units, including maternal and child health clinics.

Some 54 respondents in this category were interviewed: two-thirds were physicians and one-third were social workers. These field practitioners have direct contact with the women who are potential users of family planning. Ten to 20 years younger than their superiors, these practitioners nonetheless display similar attitudes.

Forty-one percent of the field practitioners in family planning clinics spontaneously mentioned population on their list of Egypt's problems, as shown in Table 2.3. However, when the responses are broken down into physicians' and social workers' responses, a striking picture is revealed.

Only one-fourth of the 36 physicians practicing in family planning clinics spontaneously mentioned population as a problem, whereas the proportion was three-fourths among the social workers. Aside from the tension that this asymmetry may create among practitioners of different professions in the same work place, it suggests a variable "world view." The interviewers also observed that many of the young male doctors were bearded, and more than half of the female doctors were veiled, which may suggest a conservative orientation among the physicians. This was further substantiated by a content analysis of the young doctors' problem lists. "Corruption" and "lack of religious values" were among those most frequently mentioned. Another problem mentioned (hardly encountered in the lists of higher government functionaries) was that of "Western conspiracies" to keep Muslims weak.

In all, 67 percent of the physicians reject the notion that population is a problem for contemporary Egypt. While the physicians may continue to promote family planning for other reasons (health and childspacing, for example), it seems likely that this category of field practitioner represents a weak link in the fertility-reduction component of the country's population policy.

The research team observed dissatisfaction among some physicians toward the government and its policies. When asked to evaluate the role of the government in dealing with the population issue, more than 60 percent of the doctors ranked its performance as weak or very weak. The other 40 percent gave the government a less harsh evaluation, but none ranked it as "good" or "very good." These physicians were more positive in their evaluation of the role of NGOs. Misgivings expressed about NGOs were either because of their foreign connections or because they yield to governmental restrictions.

The physicians were forthcoming, and contradictory, when asked what should be done to confront the population challenge. Half of them suggested "consciousness raising and combating illiteracy, especially among females." Another 28 percent suggested "better training to upgrade the skills of physicians in family planning." Some 14 percent recommended better coordination among various governmental agencies responsible for family planning, and making contraceptives more widely available at cheaper prices.

This seeming ambivalence among physicians was reinforced by field observations made by the research team. Few doctors would deny birth control to a woman seeking it, except for medical reasons. Twenty-two of the 36 complained of women's irregular or undisciplined use of family planning methods.

Half complained that women in their districts do not come for family planning services until they have had their fifth or sixth child. These concerns suggest that the initial failure to mention population as one of Egypt's major problems does not necessarily imply a pronatalist attitude.

Nor does a negative stance toward the government and its population policy necessarily suggest a predisposition to discourage clients from using services. We speculate, based on other evidence, that physicians' political views were shaped prior to joining the family planning program, while studying in the state university system.

The Views of Community Leaders

Thirty-six religious leaders and 36 civic leaders were selected from middle- and low-income areas, in or near localities with a sampled family planning service facility.

The religious community leaders were *Imams* (preachers) at private and government-supported mosques (18 in each). Only 4 of the 36 Imams spontaneously mentioned population in their list of problems. When the other 32 Imams were specifically probed about population, only 3 added it to their problem list. These 7 were Imams of government mosques under the supervision of the Ministry of Religious Affairs—that is, in essence government employees.

The other 29 Imams were adamant in denying that a population problem exists in Egypt—or in any Islamic country. For them, it is all “Western propaganda.” While the government Imams would not preach openly against family planning, many were as unequivocal as their nongovernmental counterparts in condemning “birth control,” a phrase our interviewers and our questionnaires did not use. But for most Imams, family planning was synonymous with birth control, and constitutes tampering with God's will.

The nongovernmental Imams more overtly opposed government policies in general and policies related to population in particular. They all indicated that they preached in mosques and advised in private against “birth control” of any kind. When asked what large families with limited means or mothers in poor health and with four or five children should do, about 75 percent of all Imams said “there will always be divine providence” and other compassionate Muslims to help. The other 25 percent would counsel such parents to “endure and be patient.”

In addition, 36 civic leaders from the communities surveyed were interviewed. A simple criterion was used—being a well-regarded officer in at least one active NGO. Fifty percent of those interviewed had multiple memberships in NGOs and all of those resided in urban communities.

As shown in Table 2.3, 58 percent of the civic leaders readily mentioned “population” in their initial problem list, compared with only 11 percent of the religious leaders. In fact, with the exception of family planning social workers, the civic leaders, more than respondents in any other category, were concerned about the population problem in Egypt. Even among those who did not spon-

taneously mention it in their problem list, another 31 percent readily added it under probing, to bring the total to 89 percent (compared with 19 percent of religious leaders).

Table 2.4 indicates that considerably more civic leaders (53 percent) have something positive to say about government efforts than their religious counterparts (6 percent). When it came to evaluating NGOs, civic leaders were predictably positive (72 percent). The researchers observed that both religious leaders and physicians tend to be more positive in evaluating NGO efforts compared with the government's efforts. NGOs were generally evaluated as more efficient and less affected by corruption.

Civic and religious leaders seem to hold common views in several areas, even if for different reasons. Many criticized the government for the ambiguity and weakness of its public policy on population and education. Many civic leaders, however, observed that the government has so far failed to obtain a definitive opinion from religious authorities legitimating family planning. While numerous respected Islamic scholars have supported family planning in Egypt since the 1930s, other leaders with popular bases of support have condemned the practice as "un-Islamic." The civic leaders feel that much of the government's efforts, regardless of efficiency, are undermined by conflicting signals about the religious legitimacy of family planning.

One other misgiving civic leaders expressed concerned the government's undue interference with the efforts of NGOs. They felt on the whole that these organizations do a good job in the field of family planning, and could accomplish much more if they were not over-regulated.

Table 2.4 Comparison of religious and civic community leaders' views on population issues

Response category	Civic leaders (N=36)	Religious leaders (N=36)
Ranking of government effort on population issues		
Positive	53.1	6.2
Negative	46.9	93.8
Total	100.0	100.0
Ranking of NGO effort on population issues		
Positive	71.9	12.5
Negative	29.1	68.8
No response	0.0	18.7
Total	100.0	100.0
Ranking of citizen cooperation on population issues		
Positive	56.3	31.3
Negative	43.7	37.5
No response	0.0	31.3
Total	100.0	100.0

Source: Ibn Khaldoun Survey data, 1993.

The Views of Egyptian Women

The ultimate success or failure of Egypt's population policy is contingent on the response of its citizens. Slowing Egypt's population growth rate has been the main policy objective since the early 1960s, pursued mainly through media campaigns and provision of family planning services. Not surprisingly, then, married women of reproductive age (15–49) are the primary target of the policy. Their reproductive behavior is shaped by many forces, the least direct of which is probably official policy. The field study investigated 503 women in their reproductive years. All had children and approximately resembled the national age distribution for women of reproductive age (34 percent from ages 15 to 30; 49 percent from 31 to 45; and 17 percent from 46 to 49). The sample was drawn from neighborhoods adjacent to sampled family planning centers and was somewhat tilted in favor of rural and urban women in poorer and lower middle-class areas.

Regarding education, 69 percent of the women were illiterate, 9 percent had been educated up to the primary level, 8 percent had secondary certificates, and 12 percent were college-educated. Nearly two-thirds of the women reside in large families of seven or more members, with 13 percent living in families of four or fewer members. The occupational levels of husbands were quite telling: though the sample was drawn from less well-to-do areas, about 18 percent of the husbands were in high-level occupations (professional, technical, and managerial), which require at least a college degree. But because they work for the government, their incomes do not allow them to live in better-off communities. These socioeconomic variables correlated highly with knowledge, attitudes, and practice of family planning.

Among the 301 women not currently using a method of family planning, 51 percent gave husbands' views and family-related matters as reasons (see Table 2.5), much higher than nationally reported figures in this respect (10–15 percent). As other recent surveys have shown, most Egyptian women know about family planning methods. The main sources of this knowledge are television (92 percent), relatives and neighbors (56 percent), radio (33 percent), and family planning centers and health clinics (24 percent). Table 2.5 shows that government-sponsored television and radio messages concerning family planning are highly regarded by most of those exposed to them. However, 15 percent of the sample considered such media messages as "useless propaganda."

Exposure to family planning knowledge obviously affects women's attitudes; 93 percent of them expressed support for family planning (Table 2.5). This disposition declined to 83 percent when it came to the ever-use of a modern contraceptive method. In the sample, about 40 percent of the women were currently practicing contraception, compared with the national average of 47 percent.

As with other groups in the survey, the interviews started with two questions about personal or family concerns and problems facing Egypt. More than in the other groups, women's problem lists were replete with immediate and concrete issues, on both the personal and national levels, as shown in the last two panels in Table 2.5.

Table 2.5 Selected indicators of family planning and problem rankings among women of reproductive age (N=503)

Indicator	Percent
Knowledge of family planning methods	
Modern methods only	76.7
Traditional methods only	2.0
Both modern and traditional methods	21.3
Sources of knowledge about family planning	
Television	92.4
Relatives and neighbors	55.5
Radio	33.2
Family planning centers	11.9
Health clinics	11.9
Newspapers and magazines	7.4
Rural social workers	4.6
Lectures, conferences, and seminars	3.2
Opinions of T.V. and radio family planning information	
Very informative	70.8
A constant reminder of proper use	12.2
Useless propaganda	15.1
Unexposed to it	2.9
Attitudes toward family planning	
Definitely supportive	93.2
Definitely opposed	6.8
Ever practiced family planning	
Yes, modern method	82.9
Yes, traditional method	6.8
No	11.0
Reasons for not practicing family planning at present (N=301)	
Religiously or morally opposed (19% of total sample)	31.0
Husband and other family-related objections (30% of total sample)	51.0
Fear of side effects (5% of total sample)	9.0
Other reasons (5% of total sample)	9.0
Frequency ranking of current personal and/or family concerns	
Health	80.1
Housing	51.5
Unemployment of a family member	30.6
Big family size	26.6
Economic	26.0
Personal	22.7
Decline of public morality	20.5
Frequency ranking of Egypt's problems	
Big family size	45.3
Housing	44.5
Health	33.8
Unemployment	17.3
Decline of public morality	13.7
Personal	13.7
Economic	10.7

Source: Ibn Khaldoun Survey data, 1993.

Some 45 percent of the women mentioned the population issue spontaneously. Many of them stated it in simple terms—for example, “big family size” or “too many people crowding everything.” However, when asked the standard question—“What about population, which some think of as a problem?”—78 percent readily agreed that population is a problem in Egypt (not shown in table). Along with civic leaders and social workers, women overall seem more prepared than other, chiefly male-dominated groups to regard population as a serious problem.

Cross-tabulations of education and other sociodemographic correlates indicated that illiterate women, who made up 68 percent of the sample, are more concerned about their own families’ health (83 percent), housing (57 percent), and unemployment (32 percent) than they are about family size per se. These women ranked “big family size” 8 out of 10 on their problem lists. Women with a university education, on the other hand, while also primarily concerned about personal and family health (71 percent), had other priorities that were quite different: big family size ranked second (64 percent), followed by personal problems (55 percent).

All in all, the survey responses reveal a deep divide among various groups in Egyptian society regarding the role of fertility and population growth as a source of societal problems. Policymakers can best be described as neutral or unaware, while community actors are more likely to be either proponents or detractors of current policies.

STATE, CIVIL SOCIETY, AND WOMEN: CONVERGENCE OR DIVERGENCE OF INTERESTS?

National decisionmakers who are responsible for Egypt’s population policy have formulated various comprehensive and well-intentioned programs to serve the policy objectives, including efforts to enhance women’s education, training, employment, and public participation. But the coordinators of the policy—the National Population Council (and, more recently, the Ministry of Health and Population)—have no real control over other government agencies that implement those programs. Conversely, as was seen from the field study, minimal interest or commitment was shown by most cabinet-level decisionmakers, technocratic executives, and some physicians toward the family planning component of population policy. This combination of weak commitment and fragmented authority frustrates even the most dedicated efforts of policy implementers.

Rivalries and Cleavages

Likewise, intragovernmental rivalries have undermined the effective implementation of Egypt’s population policy. For years, conflict persisted among the NPC (and its predecessors), the Ministry of Health, and the Ministry of Social Affairs. The intensity of the conflict frustrated President Mubarak to the point

where he resigned as chairman of the NPC executive board, and delegated the job to his prime minister. Power struggles at the top are often devolved to the governorate level or even down to the field units. It is hoped that these rivalries will diminish with the establishment, in 1996, of a joint Ministry of Health and Population to handle overall coordination.

The more serious cleavage in Egypt today, which undermines many public policies, is a three-way conflict between the government, civil society, and militant Islamist groups. We saw how divergent, for example, were the views of community civic and religious leaders. All three parties are fighting for a share of Egypt's public policy agenda, often using gender issues as the battleground. Both the government, with its centralized hierarchic traditions, and religious groups, with their absolutist dogma, seek full control of that agenda, and the conflict is played out partly over women's reproductive intentions and behavior. For its part, civil society groups are trying to recapture and expand their share of influence.

Each of the three actors has its own, albeit unequal, arsenal of communication weapons to deploy. The government has the powerful official media, institutional and financial resources, some 4,000 maternal and child health clinics, and 20,000 government mosques. However, its forces have been demoralized by bureaucratic inertia; they may comply with orders, but they do so with little enthusiasm.

The Islamic activists have at least two opposition papers (*Al-Shaab* and *Al-Ahrar*), 40,000 nongovernmental mosques, and thousands of activists to preach, teach, and distribute cassette tapes, with messages often accusing family planning programs of being "Western plots" against Muslims. Their forces comprise single-minded zealots who have managed in some cases to penetrate and influence universities and governmental agencies.

Civil society has some 20,000 local trade and professional unions, political parties, NGOs, cooperatives, youth clubs, and business associations. Only a fraction are directly involved in provision of family planning services, though many are concerned with development and are generally committed to empowerment and freedom of choice for all. But civil society is muted by the government through over-regulation and by the Islamic activists' powerful local organization.

In the context of family planning, civil society has become an uneasy ally of the government. In fact, our interview findings showed the greatest credit for effective family planning services given to the NGO sector by women and employees of government services. Similarly, during the preparations for and controversy over the 1994 ICPD, Egypt's civil society mobilized its forces through the Egyptian National NGO Committee for Population and Development, and allied itself closely with the government (against Islamic activist detractors). President and Mrs. Mubarak hailed the efforts of Egypt's NGOs on that and several subsequent occasions.¹² As a result, during the summer and fall of 1994, hopes were raised about reinvigorating Egyptian NGOs and lifting

the controls on them. Unfortunately, the official insistence on maintaining the status quo frustrated these hopes and kept the potential of civil society substantially unrealized over the following three years. A newly appointed Minister of Social Affairs in mid-1997 raised hopes once again for regulatory reform.

In the Aftermath of ICPD

The highly successful International Conference on Population and Development resulted in a broad-ranging consensus on world population goals. During the months preceding the conference, an unprecedented national debate on population issues took place in Egypt. The conference itself dominated the media for several months. Members of more than 500 Egyptian NGOs, 800 journalists, and 1,500 youth volunteers participated in conference-related activities. In brief, the Egyptian people were fully exposed to the event, and, ultimately, most were proud of their country's association with a successful conference.

The two years following the ICPD witnessed sustained efforts by the Egyptian government to capitalize on that success both at home and abroad. Several programs inspired by the ICPD's Programme of Action were funded and put into effect. In particular, increased investments were made in girls' education and women's employment, and efforts were made to introduce reproductive health services alongside family planning programs. In another important development, Egypt's NGOs and civil society organizations were given greater freedom to operate in the population field. International donors like the World Bank, the European Union, the United Nations Population Fund (UNFPA), and UNICEF increased their technical and financial support for Egypt's population programs.¹³ And desert settlement programs received increased funding and public attention.

During the same period, two other international events fueled debate over population and reproductive health. The Social Development Summit in Copenhagen (March 1995) and the Fourth World Conference on Women in Beijing (September 1995) raised alarms about "gender" as a dangerous imported concept, though Egyptian activist women were quick to reject that assertion. Adding to the Egyptian debate was the particularly sensitive issue of female circumcision, or female genital mutilation (FGM). A Cable News Network report on the practice of FGM in Egypt, televised during the ICPD, angered many Egyptians and sparked an official investigation. When asked about the practice, President Mubarak claimed that female circumcision was very limited and was on the decline (*Al-Ahram*, 12 September 1994). Some religious leaders clashed over whether FGM was an Islamic practice.

Many health professionals and women activists argued that the practice was widespread and detrimental to women's health and wellbeing. In fact, the 1995 EDHS found that 97 percent of the married women aged 15 to 45 years had experienced some form of circumcision. In an attempt to discourage informal practitioners, the Minister of Health allowed FGM to be carried out in public hospitals by government doctors—an action that sparked local and in-

ternational outrage and eventually forced him to rescind the order. Public debate and mobilization over FGM has continued.

Greater consensus was shown in other areas of population policy. The president and other top officials continued to refer to the vital importance of controlling population growth if sustainable development is to be achieved. In a statement to newly appointed governors in 1996, Mubarak pointed out that "the major problem facing reform is the population increase. In my 15-year presidency, Egypt's population has increased by 18 million. Income per capita would have been [US]\$990 (instead of [US]\$700) annually should we have grown half that much. It is this population increase which has adversely affected opportunities and created the unemployment problem" (*Al-Ahram*, 18 January 1996). The same message was reiterated by other officials and the state media.

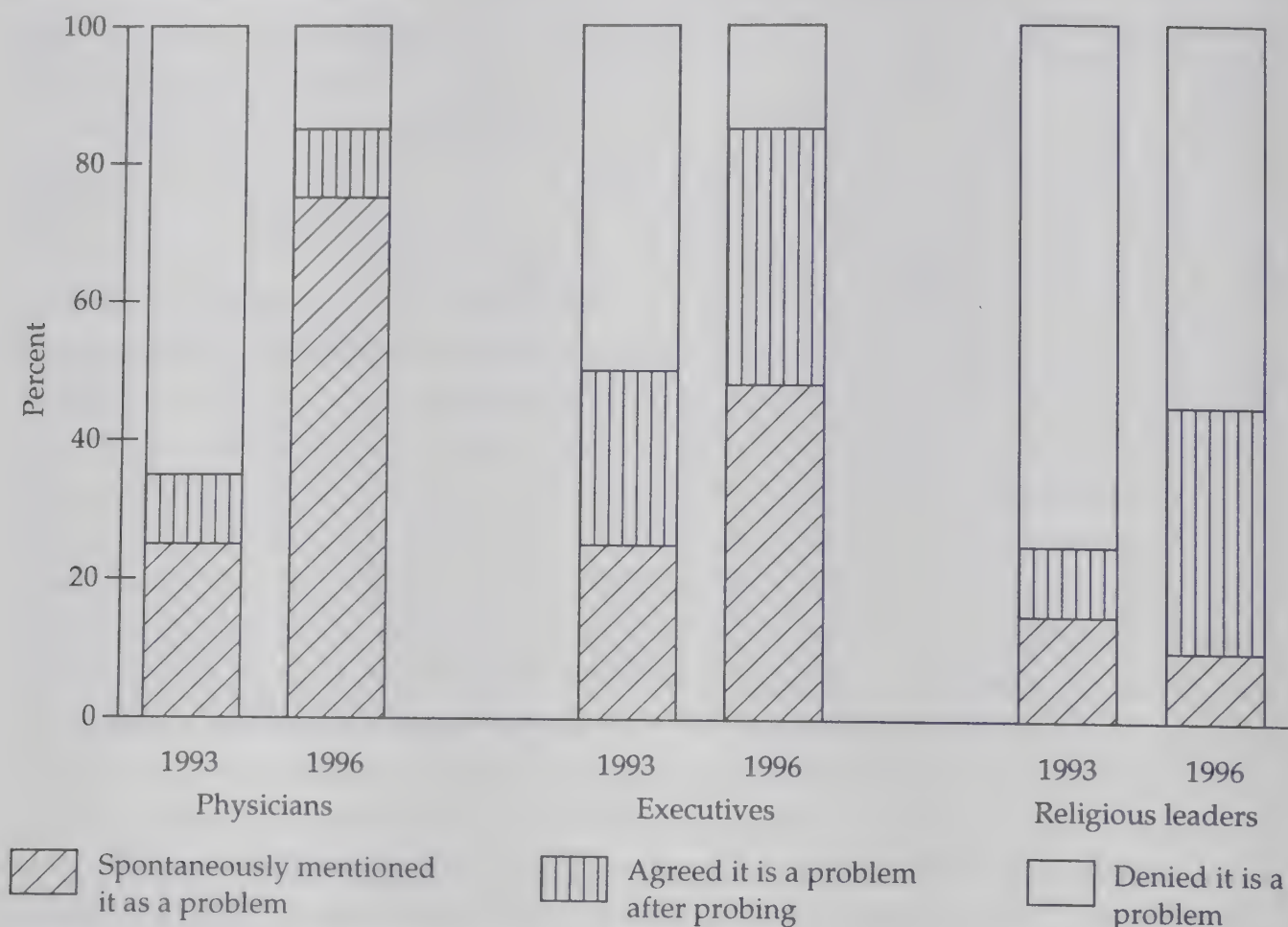
All of this raises the question of how such concerted national policy attention affected relevant stakeholders vis-à-vis population issues. To address the question, we returned to some of the key actors in mid-1996 and asked them the same questions we had addressed before the ICPD. We hypothesized that the ICPD, the national debate it generated, unprecedented official attention, and the growing involvement of NGOs were all significant intervening variables between the two investigations.

Due to time and resource constraints, roughly half the categories and sample size of the 1993 survey were included in the 1996 follow-up. Thus, we sampled from four governorates instead of nine—two in Upper Egypt (Assyut and Menya) and one each in Greater Cairo (Giza) and Lower Egypt (Sharkiya). We also reduced the number of respondent categories from six to three: middle executives with direct responsibility for policy implementation at the governorate level (Directors General of Health, Social Affairs, Education, Information, Population and Family Planning, and Religious Endowments); practicing physicians in family planning and maternal health clinics; and community religious leaders (mosque preachers). This brought the total number of follow-up interviews to 76. These were the actors whose attitudes toward Egypt's official population policy were mixed or in some cases negative in the 1993 study.

Four survey questions were added to those asked in 1993, to cover the ICPD event and its aftermath. In this round we also administered the questions to a larger sample of 166 senior Egyptian civil servants from departments and ministries not directly involved in population policymaking or its implementation. The objective here was to detect the resonance of population issues among a wider range of opinion leaders in Egypt. Interviewing was conducted from April to June 1996 by the same team and under similar conditions described for the 1993 survey.

While sample sizes are small and unrepresentative, we believe the findings are indicative of significant shifts in public perception since 1994. Figure 2.1 compares the responses of three categories of policy actors one year before and two years after the ICPD. The most dramatic change is among physicians: when asked in 1993 to list the country's major problems, only 25 percent of

Figure 2.1 Changes in attitudes toward population as a problem among various stakeholders, 1993 and 1996



Source: Ibn Khaldoun Survey data, 1996.

those sampled mentioned population spontaneously; three years later, the fraction jumped to 75 percent. By the same token, though less dramatic, middle executives in charge of policy implementation have become more aware of the population problem. Half of them mentioned it spontaneously among the ten major challenges facing Egypt, compared with one-fourth in 1993. The least change was among community religious leaders. In fact, slightly fewer of them in 1996 than in 1993 mentioned population spontaneously in their list of major challenges. But when they were probed, the fraction jumped to 50 percent in 1996, compared with only 19 percent in 1993. Here, we may remember that about half of the sampled religious leaders are government employees, in state-owned and state-run mosques, as distinct from nongovernmental mosques in which the preachers do not have to abide by official directives. This difference may explain in part why many of the state Imams now readily agree with the probing statement, "Some people include population as a major problem." The percentage of our total sample that spontaneously or after probing mentioned population as one of Egypt's major problems more than doubled between 1993 and 1996, from 20 to 46 percent without probing and from 36 to 72 percent with probing. While we cannot attribute all of this dramatic change to the ICPD alone, the conference was no doubt a significant trigger.

This conclusion is suggested by the 1996 survey findings on other questions. For example, as shown in Table 2.6, 82 percent of the sample knew about

Table 2.6 Attitudes toward the International Conference on Population and Development, as reported in 1996

Question	Physicians (N=28)	Executives (N=24)	Religious leaders (N=24)	Total (N=76)
Did you approve of Egypt hosting the ICPD?				
Supportive	96.4	95.0	54.2	81.9
Neutral	0.0	5.0	0.0	4.2
Against	3.6	0.0	45.8	13.9
Do you think Egypt benefited in any way from the ICPD?				
Status and image of Egypt	20.0	44.4	35.7	33.8
Gain knowledge of the problem	53.3	30.6	21.4	37.5
Raise Egyptian awareness of the problem	13.3	11.1	0.0	10.0
Other benefits	13.3	13.9	42.9	17.5
Have you followed up on ICPD recommendations?				
Yes	60.7	100.0	45.8	66.7
No	39.3	0.0	54.2	33.3
How would you rate the Egyptian government's response to the population challenge since the ICPD?				
High	50.0	20.0	20.8	32.4
Average	25.0	55.0	8.3	26.4
Low	25.0	25.0	71.0	30.2

Source: Ibn Khaldoun Survey data, 1996.

and approved of Egypt's hosting of the ICPD. The percentage was far higher among physicians, who had evidenced somewhat negative attitudes toward population issues in 1993. It is possible that, as they saw the conference unfold firsthand or had greater access to its documents, they developed more positive attitudes. This can be inferred from the responses to a question that asked respondents whether they thought Egypt had benefited from the conference. More than half of the physicians said the conference added to their knowledge of the problem. State executives, on the other hand, saw the ICPD primarily as a means to improve the country's status, prestige, and image. The few religious leaders who supported hosting the ICPD saw it as an occasion to present the Islamic point of view on the issue of family planning, which some of them support, and of modern contraception, which many of them deplore.

CONCLUSION

After several decades of ambiguity, Egypt's population policy seems to be proceeding on a well-defined track. A review of Egyptian public concern over population issues reveals a number of important lessons.

First, three decades of warnings from Egypt's nongovernmental organizations, starting in the early 1930s, were required before the government issued

its initial public declaration regarding the population problem in the early 1960s. In the interim, the country's population had doubled. This delayed government response, in turn, was hampered for more than two additional decades because of competing paradigms concerning the problem, oscillating commitment of the top leadership, and conflict between bureaucracies over who was to do what. Meanwhile, Egypt's population doubled once more.

Second, of the three decades of government concern, only during 1960–70 and from 1986 onward did the government and civil society actively and jointly pursue the primary objective of the policy. During the 1960s, the annual rate of population growth was cut from 2.8 to 2.1 percent. The 1970s was a lost decade for Egypt's population policy. Annual growth rates inched up again to reach an all-time high of 3.1 percent in 1980. From 1986 to 1994, it was cut from 3.0 to 2.2 percent. Here lies the promise of what can be done if the top leadership displays a strong and sustained commitment, and if organizations of civil society are allowed wider freedom to act. Taken together, the three decades of Egypt's population policy achieved between one-third and one-half of what could have been achieved with more forceful commitment and implementation. In effect, a sluggish population policy resulted in a mere 5 million fewer people in 30 years.

Third, the results of the last ten years are impressive. But the momentum achieved recently is threatened by a number of counterforces. The renewed presidential commitment to a three-pronged population policy (reduction of the population growth rate, spatial redistribution, and improving overall socioeconomic status) is not matched by equal commitment on the part of many cabinet members, or by top- and middle-level government executives. The more unexpected threat to the policy, however, comes from local-level actors: some physicians in family planning and maternal health centers, and religious community leaders. These two groups are split internally, with some elements hostile to government policies in general and to the population policy in particular. The pronatalist attitudes are a consequence of a radical Islamic ideology that has been spreading among young, educated Egyptians. It attracts followers in some medical schools, where students are exposed to little social science training.

Fourth, the pronatalist stance of radical Islamic activists is supported to some degree by deep-seated traditional values and reproductive norms in rural and poorer urban areas. Nevertheless, these forces have not succeeded in monopolizing Egypt's public agenda. The government has several actual and potential allies. We have shown that parts of the government bureaucracy and most civil society organizations are committed to Egypt's population policy. Because of raised awareness, health reasons, and/or socioeconomic pressures, most Egyptian women have become positively disposed to family planning, and one-half of married women are contraceptive users. Approximately another one-fourth are willing to use contraception under the proper conditions—for example, when their husbands and families approve, when they have easier access to better-quality medical care, or when they can receive assurances against side effects of methods.

Finally, both strategies urged in the worldwide population debate (provision of family planning services and overall development) have been tried in Egypt. The one period in which provision of services and intensive development were simultaneously emphasized, the 1960s, produced the best results with regard to the reduction of the population growth rate. But to characterize the outcome of the two strategies in such terms is overly simplistic. Many intervening factors will determine the outcome of any strategy. We submit that clearly articulated objectives and commitment to educating and empowering women are the most important of these intervening variables. The next most important factor is to increase the freedom available to Egypt's civil society organizations, in order to unleash their development potential. Sustained commitment on the highest level of decisionmaking is also critical, as is revamping medical school curricula to provide wider exposure to social science training. The battle over the future of the country's population policy—indeed, over Egypt's destiny—is contingent on a forceful commitment to achieving and sustaining all of these conditions.

Notes

1. For an elaboration of the debate see Dixon-Mueller (1993) and Finkle and McIntosh (1994).

2. See a detailed account of these early warnings by Egypt's intellectuals and NGOs in Darwish (1989), Cleland (1936), Mahran (1994), and Abdel Hakim (1994).

3. Notable among these were three Egyptian NGOs: *Al-Nahda* (Renaissance), *Al-Ruwwad* (Pioneers), and the Egyptian Feminist Union. For details, see Darwish (1989: 74–85).

4. See the text of Nasser's speech on 23 July 1955, in *Al-Ahram* (Cairo Arabic daily), 24 July 1955.

5. See Abu-Lughod (1985).

6. Egyptian pharmacists often give basic medical advice and prescribe medicines to their clients upon request.

7. See the World Bank's *World Development Report* for various years.

8. See interviews with President Mubarak in *Al-Musawwar* (weekly), 24 September 1993, and *Al-Ahram*, 12 November 1993. On these and other recent occasions, the president placed population fourth on a

six-point national agenda for the remainder of the 1990s.

9. See President Mubarak's speech on the occasion of receiving the UN Population Award in Geneva on 14 June 1994, published in *Al-Ahram*, 15 June 1994.

10. See the briefings on a series of presidential meetings with the Cabinet and the ruling National Democratic Party, headlined in *Al-Ahram*, 27 December 1993 and 6 January 1994, respectively. See also Mubarak's opening speeches to the ICPD on 5 November 1994, and to the Egyptian Parliament, 11 November 1994.

11. These executives were interviewed in the summer and early fall of 1993. Subsequently, some left their positions in a cabinet reshuffle that occurred in October.

12. See Suzanne Mubarak's speeches to the ICPD NGO Forum, 4 November 1994; proceedings of the American University in Cairo Conference on "Continuing with Our Children," 4 December 1994.

13. These efforts were described one year after the conference in an official document; see Ministry of Population and Family Planning (1996).

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PRAVIN VISARIA AND VIJAYLAXMI CHARI

India's Population Policy and Family Planning Program: Yesterday, Today, and Tomorrow

In 1951, India became the first country in the developing world to initiate a state-sponsored family planning program. The Indian government saw the program not only as a way to lower the country's fertility level and population growth rate, but also as part of a broader economic and social development plan. Now, more than 45 years later, India is shifting its approach to population policy.

The country has seen a significant decline in its fertility level since the 1970s, and the evidence points to a particularly accelerated decline since 1985. Yet, India's population policymakers often receive criticism from the international community as well as from Indian citizens, including social scientists, activists, and journalists, for the manner in which the family planning program operates on the ground. Unfortunately, some Indian analysts seek publicity by condemning family planning bureaucrats and functionaries for both real and imagined mistakes.¹ The negative attitude of members of the international community perhaps reflects their marginal role in the Indian program relative to, for example, the Indonesian program.² Moreover, some honorable exceptions apart, the international community is understandably less concerned about the means adopted to lower fertility in Indonesia and elsewhere than about the outcome—that is, the actual decline in fertility. As a result, most comparative assessments overlook the constraints under which the Indian program and policy have to operate.

A balanced assessment of the evolution of the Indian population policy and family planning program—one that notes the government's achievements as well as its failures—is rare. In this chapter, we attempt to provide such a balanced assessment on the basis of a careful study of (1) the various five-year

plans, which have articulated the policy perspective, (2) the annual yearbooks issued by the Ministry of Health and Family Welfare (MOHFW), and (3) the perceptions of the functionaries, political workers, bureaucrats, and the public about various issues related to the Indian population policy.

The chapter begins with a review of the history of India's decisionmaking process regarding its population policy and the shifting emphasis on various activities related to population growth. The current status of the population policy and the family welfare program, including both their achievements and their limitations, is assessed.

Next, findings are presented from two large surveys conducted in Gujarat and Kerala states during 1989 and 1991, respectively. The responses of nearly 16,000 households in the two states provide a qualitative view of the public perceptions of various population issues. Findings from interviews with 21 politicians and bureaucrats, some of whom have spent most of their lives working in the population field, are then presented.³ In addition to these interviews, two focus group discussions were conducted with family planning program functionaries at the grassroots level, to assess the program's activities in the field.

Following the presentation of the focus group findings is a brief review of the country's progress in terms of literacy and school enrollments, which are inevitably linked to population policy. It is argued that the deficiencies in the implementation of various policies partly reflect India's democratic structure and the plurality of its population rather than an inadequate recognition of the actions that need to be taken.

The chapter ends with some conclusions about the new directions of the family planning program and the commitments made by India as a signatory to the Program of Action adopted at the International Conference on Population and Development, held in Cairo in September 1994.

INDIAN POPULATION POLICY, 1951-96

India's earliest population policy, like the policies in many other countries, is not articulated in a single document. Nevertheless, the various documents relating to India's five-year plans for social and economic development contain an excellent record of the milestones and the factors guiding various decisions concerning the country's population policy.

The Origin of India's Concerns About Population Growth

It is often argued that population policies in developing countries reflect, to a large extent, pressure from industrialized countries rather than an indigenous consensus in favor of limiting population growth. Even if this assertion is true, India is an exception, as evidenced by the country's history both before and after it achieved independence from Great Britain in 1947.

The concern about the fertility level (the number of children born to Indian women) and about the rate of population growth was not imposed on India from abroad. The country's leaders had been exposed to the develop-

ments in Western countries and did not want India to lag behind. During the first two decades of the twentieth century, the rate of population growth in India was negligible, and the decade of accelerated population growth after 1921 was viewed as a period of peace and prosperity. However, the increased growth rate revived a debate about whether India was overpopulated and whether socioeconomic development and the eradication of poverty depended on restraining population growth. A recurrent view in these debates was the assertion that India was one of the richest countries in the world in terms of resources while having some of the world's poorest people. The country's widespread poverty was considered a result of the ruthless exploitation of its resources by the colonial regime. Independence was expected to end the drain of India's wealth by the expatriates and initiate a rapid march toward prosperity.

In February 1939, Gyan Chand, a leading Indian economist, observed that, "judged from any point of view, a check on the growth of population of India is an urgent practical necessity. We cannot . . . make India a much better place to live in without concerted efforts on a national scale." According to him, "an excess of numbers" was frustrating "the limited efforts" being made to "combat and overcome" the evils of "death, disease, ignorance and poverty" (Gyan Chand 1939: 323). Meanwhile, during the early surge in India's population growth rate, Professor R. D. Karve opened the country's first family planning clinic in Poona in 1923. In 1928, with the support of many influential persons, including high court judges, a neo-Malthusian League was formed in Madras city. It published a journal in 1929 emphasizing the need to control the birth rate. In 1930, the native state of Mysore, with its enlightened "prime minister,"⁴ opened the first government clinic in Bangalore, although it attracted few clients. A Society for the Study and Promotion of Family Hygiene was formed in Bombay in 1935, and the All-India Women's Conference (an organization of elite educated women) began advocating the adoption of voluntary birth control. Despite their limited impact on India's population growth rate, these initiatives—which reflected the interest of the Indian elite in family limitation—culminated in the establishment of the Family Planning Association of India (FPAI) in 1949. The founder and president of the FPAI, Lady Dhanvanthi Rama Rao, was the wife of the governor of the Reserve Bank of India; and for several years she was an influential member of many family planning committees appointed by the government of India.

While India's elite were advocating family planning, there was some ambivalence about contraceptive use within the ranks of India's freedom movement (the movement to gain independence from British rule). Nonetheless, in 1938, Subhash Chandra Bose, president of the Indian National Congress, advocated a restriction of India's population size. He set up the National Planning Committee (NPC), under the chairmanship of Pandit Jawaharlal Nehru, who became the first Prime Minister of independent India, to prepare a plan for the social and economic development of India after it gained independence. Nehru appointed a subcommittee chaired by a leading economist, Dr. Radhakamal

Mukerjee, to decide the proper approach to various aspects of India's population problem. The report of the subcommittee, reviewed by the parent body in May 1940, led the NPC to resolve that "measures for the improvement of the quality of population and limiting excessive population pressure" were "necessary" and that "in the interest of social economy, family happiness and national planning, family planning and a limitation of children are essential, and the State should adopt a policy to encourage them." While considering it desirable "to lay stress on self-control, as well as to spread knowledge of cheap and safe methods of birth control," the committee supported the establishment of birth control clinics and an effort to "prevent the use or advertisement of harmful methods." The latter caveat presumably referred to abortion, which the committee recognized as "not uncommon" and as a procedure that was generally carried out by "highly dangerous and damaging" crude methods. The NPC supported the "gradual raising of the marriage age," "discouragement of polygamy," and a eugenic program including "the sterilization of persons suffering from transmissible diseases such as insanity or epilepsy"; but it did not specifically endorse the subcommittee's suggestion to promote the idea of spacing births two to four years apart and limiting the total number of children in a family to four.⁵

These events are noted here at length because they were reflected in the developments in post-independence India. For many years, India's leaders admired the then-apparent Soviet success in planned economic development and wanted to develop a similar socialist society. By emulating certain aspects of the Soviet system, they believed, India's poverty could be quickly eradicated. India's leftist political leaders often cited Marxist writings on population and the pronatalist policies of the USSR to illustrate the need to stress development over population control as the urgent national imperative.

The Health Survey and Development Committee, appointed in 1943 by the Government of India under the chairmanship of Sir Joseph Bhore, anticipated as early as 1946 that improvements in health and the control of disease and famine would cause an increasingly serious population growth problem. The Committee considered the deliberate limitation of family size to be "advisable" and noted that it could not be achieved through self-control "to any material extent." The Committee was divided about a state-supported program to promote birth control, but it supported state control of (1) the manufacture and sale of contraceptives, (2) public assistance in research for a safe and effective contraceptive, and (3) continuous study of the population problem and its related factors (India, Health Survey and Development Committee 1946: 80–81).

As an independent India began to plan for economic and social development with a welfare-state orientation, it needed estimates of the future population or the number of consumers and producers (that is, potential workers) and their spatial distribution. During this period, Indian experts deliberated among themselves and were not influenced by external advisers. Subsequently, however, expatriate experts (that is, Indians and others living abroad and non-

Indians living in India) did play an important role in a number of ways, including (1) convincing India's leaders to recognize how the population growth rate affected the pace of economic development, (2) shifting from a clinic-based to an extension (visiting health worker) approach to providing family planning methods, and (3) establishing a target-based monitoring and evaluation system within the family planning program. These developments are discussed below.

Broad Focus of the Initial Policy Formulations

The Planning Commission (set up in March 1950) recognized the need for a population policy. The following March, the 1951 Census reported that the population growth rate in India during the 1940s had remained the same as during the 1930s (about 1.2 percent per year). Because of a weak data base and a limited understanding about population trends, the rate of growth observed during the 1940s was projected to continue over the ensuing 30 years. In the first five-year plan, three alternative scenarios were presented to illustrate the possible trends in the growth rate of per capita income or consumption (Planning Commission 1952: 20–21).

The Planning Commission's Panel on Health Programs set up a Committee on Population Growth and Family Planning to review the situation. Incorporating its key recommendations, the Draft Outline of the First Five-Year Plan, which was released in July 1951, reported that "population policy is . . . essential to planning" and family planning is "a step" toward "improvement in health, especially of mothers and children" (Planning Commission 1951: 16, 206–207). The macro-effect of family planning—that is, a lowered rate of population growth—was expected to occur only "over a period of time," but it was expected to help improve health "immediately" because "frequent and ill-spaced births undermine the health of the mother" (Planning Commission 1951: 206).

The Planning Commission accepted the recommendations of the Committee on Population Growth and Family Planning with respect to sterilization, as follows:

1. The State should provide facilities for sterilization or for giving advice on medical grounds.
2. Such help and advice should not be withheld from others who seek and need it on social and economic grounds. Such services, however, should be provided to the extent that the personnel in hospitals and health agencies can undertake them in a manner consistent with their other duties.

In addition, state assistance and financial aid were proposed for collecting, studying, and disseminating national and international information on all aspects of family limitation, for countering the ill effects of incorrect information, and for conducting research on developing inexpensive, safe, and efficacious methods of birth control suitable for all classes of people. In recognition of some members' objections to the promotion of contraception, the Committee also proposed that noncontraceptive methods of family limitation be investigated, along with consideration of raising the age at marriage.

The draft outline also noted that the “increasing pressure of population” on “inevitably . . . limited” natural resources “retards economic progress and seriously limits the rate of extension of social services, so essential to civilised existence” (Planning Commission 1951: 16). The complexity of the population problem, including its economic and social aspects, was recognized but the planners held that an increase in India’s labor resources would weaken, not strengthen, the economy.

The final draft of the First Plan, released in December 1952, highlighted the “urgency of the problem of family planning and population control” as a result of the decline in the death rate (Planning Commission 1952: 522, ¶105). It noted that the improvements in the standard of living required for lowering the birth rate were “not likely to materialise if there is a concurrent increase of population.” Furthermore, the plan noted, population control or stabilization of the population at a level consistent with the requirements of the national economy could be achieved only through a reduction in the birth rate. But the main appeal of family planning was its potential for improving the health and welfare of the family.

The Planning Commission that was bold enough to make India a pioneer in the field of population policy in 1951 was hesitant in its approach. Some of that hesitancy stemmed, of course, from the fact that there were no precedents to follow or experiences from which to learn, but the Commission had to reckon with other factors as well. The Health Minister of India during 1947–52, Rajkumari Amrit Kaur, had been a close associate of Mahatma Gandhi and was opposed to contraceptive use and favored abstinence. When, in April 1952, a Population Policy Committee was appointed under the chairmanship of the Minister of Planning, with the Health Minister and others as members, these differences came to a head. The Minister of Planning, Gulzari Lal Nanda, sought the intervention of the Prime Minister, who assured the Minister that it was “absurd” to limit the consideration of the question of family planning “on the lines suggested by Amrit Kaur.” The Prime Minister disagreed “with her approach entirely” and promised to attend the next meeting when the matter was discussed. He supported the view favoring the promotion of contraceptive use. Prime Minister Nehru himself felt confident about supporting an even bigger population, provided production increased. Yet, he wanted population growth to be “restricted.”⁶

The instruments designed for achieving the objectives of the First Plan with respect to the promotion of maternal and child health (MCH) and family planning were rather limited. The Planning Commission created two committees, one to address policy and approach, and the other to address research and programs on population and family planning. The main activities of these committees were to support the establishment of family planning clinics, to encourage and review ongoing research, to develop procedures for awarding grants and monitoring the grantees’ progress, and to establish an institutional base. The Commission allotted a sum of Rs. 6.5 million (US\$1.35 million at the then-prevailing exchange rate) for a family planning program in the plan of the

Ministry of Health.⁷ The Commission also considered it "desirable" (1) to set up "at a later date" a population commission to assess the problem, (2) to consider different views on the subject of population control, (3) to appraise the results of experimental studies, and (4) to "recommend measures in the field of family planning to be adopted by the government and the people" (Planning Commission 1952: 524, ¶108).

The Second Five-Year Plan, 1956–61, was formulated with a limited data base on population trends. Its assumptions relating to population trends allowed for a slight rise in the intercensal rate of growth from 12.5 percent during the 1950s to 13.3 percent during the 1960s and to 14 percent during the 1970s (Planning Commission 1956: 8, ¶13). Among the five specific objectives of the "health programs" during the second plan was "family planning and other supporting programs for raising the standard of health of the people" (Planning Commission 1956: 533, ¶1). The opening sentence of the section on family planning noted that "the problem of regulating India's population from the dual standpoint of size and quality is of the utmost importance to national welfare and national planning." Expressing satisfaction with the progress of the family planning program during the First Plan period, the Second Plan called for the further development of the program on "systematic lines," for the continuous study of population problems, and for a "more or less autonomous . . . central board for family planning and population problems." Among the aspects of the program of the Central Board were listed not only the extension of family planning services, the establishment and maintenance of training centers, demographic research, and research into the biological and medical aspects of reproduction and of population problems, but also the "development of a broad-based program of education in family living, which should include within its scope, sex education, marriage counselling and child guidance" (Planning Commission 1956: 553, ¶55). Interestingly, some of these themes form components of the "reproductive health approach" to the family planning program and have been emphasized in the Program of Action adopted at the International Conference on Population and Development held in Cairo in 1994.

Once again, the policy instruments were limited except for the possibility of integrating family planning and health education activities with community development. (The term "community development" in the 1950s and 1960s was synonymous with "rural development" and did not connote a neighborhood program.) The planners recommended that family planning be made a part of the health education program they had proposed, and health education was to be promoted throughout rural India under the umbrella of a "Community Development Program." The program aimed at improving India's agricultural productivity and, through it, rural living conditions via a large network of village-level workers who contacted people in their homes.

Introduction of Sterilization and Incentives in the Indian Program

India's urban elite of the 1940s and 1950s were familiar with the increasing popularity of sterilization (usually hysterectomy) among their peers as a

method of terminating childbearing. The experimental research undertaken during the 1950s included two studies to assess the acceptance of the rhythm method as well as a longitudinal study to assess the adoption of foam tablets as methods of birth control. Other methods considered for promotion in India's family planning program included coitus interruptus (exclusively or with foam tablets), spermicidal jelly, and the diaphragm and jelly (Raina 1988: 36–37).

The KAP (Knowledge, Attitudes, and Practice) surveys undertaken in parts of the country at the time indicated a widespread desire to limit the size of the family below the average number of births per woman, or total fertility rate, of 6.0 or more. However, the rate of contraceptive adoption continued to be disappointing.

In this setting, in the late 1950s, Mr. R. A. Gopalaswami, who had conducted the 1951 Census, was chairman of the Program Committee of the Family Planning Board of Madras (now Tamil Nadu) state. Under his leadership, government hospitals began to offer facilities for free sterilization, initially for women but later for men as well. While the central government initially remained neutral, the state government promoted surgical contraceptive methods. In 1959, the government of India accepted sterilization as one of the recognized methods of family size limitation. Also in 1959, after considerable discussion, the government of Madras began to offer "poor" acceptors of sterilization in Madras city a modest compensation of Rs. 30 to cover transportation costs and the loss of wages during the period of convalescence. The scheme was later extended first to selected rural areas and then to the entire state (Gopalaswami 1962.) The government also began to give a modest sum to the canvassers, who helped to mobilize the clients for sterilization.

Within the sterilization program, vasectomy was promoted throughout the country as a relatively inexpensive permanent method, one that eliminated the need to repeatedly use contraceptives. Other states such as Maharashtra established special camps to provide sterilization facilities virtually at the doorstep of the rural population.

The central government assisted the expansion of sterilization facilities throughout the country and prescribed standards that family planning providers were expected to meet in offering their services—for example, obtaining the written consent of the spouse and written verification (initially from both spouses, but later only from the spouse who was undergoing the sterilization) of the acceptor's age and number of living children.

The continuing role of sterilization and the compensation or incentives given to acceptors, motivators, and canvassers in the Indian program has been a subject of recurrent debate and controversy, which are discussed later in this chapter.

A Growing Concern About the Rate of Population Growth

The Third Five-Year Plan document was released soon after the 1961 Census had confirmed the rise in the average annual rate of population growth to

about 2 percent—which had been projected by some Western demographers based on the decline in mortality that resulted from the promotion of public health programs. The revised population projections in an appendix to the Third Plan (Planning Commission 1961: 752, ¶4) recognized both the complex nature of the changes in the birth and death rates and the speculative character of the assumptions underlying the projections. Recognizing that the family planning program raised “problems of great complexity,” the Plan said that “sustained and intensive efforts are required over a fairly long period before family planning can become a popular movement and a part of the accepted attitudes of the people” (Planning Commission 1961: 46, ¶39). The authors of the Third Plan also noted the association between areas of acute poverty and high population density (Planning Commission 1961: 20, ¶19). They noted, too, that a high population growth rate made it difficult to increase the rate of saving, which was vital for higher productivity and incomes (Planning Commission 1961: 22, ¶5). Population growth absorbed “a large part of the increase in output”; and an improvement in health and sanitation might lower the death rate, which would result in a higher growth rate. Therefore, the Plan noted, “the objective of stabilising the rate of growth of population over a reasonable period must . . . be at the very centre of planned development” (Planning Commission 1961: 25, ¶13). In a sense, the Third Plan marked a subtle shift in the emphasis of the Indian family planning program from the welfare of women and children to the macro-objective of stabilizing the rate of population growth and thereby accelerating the pace of economic and social development, including the alleviation of poverty.

The Third Plan proposals had been considered by a special committee appointed by the Ministry of Health and by the Planning Commission’s Panel on Health (Planning Commission 1961: 676, ¶58). Accordingly, the Third Plan also suggested that “family planning activities will be integrated with normal health services[,] and family planning services including facilities for sterilization will be provided through medical and health centers” (Planning Commission 1961: 72, ¶35). Family planning education was considered a way to improve the quality of life and was to be interwoven with other “constructive activities,” especially the work of the primary health centers, community development blocks (which usually include about 100,000 people, and are part of a district), and voluntary organizations (Planning Commission 1961: 676, ¶62).

In response to the reservations of social scientists and others about the adverse impact of the promotion of sterilization and other contraceptives on the traditional values and strengths of Indian society, the Third Plan recommended an emphasis on “moral and psychological elements, on restraint and on such social policies as education of women, opening up of new employment opportunities for them and raising of the age of marriage.” It also stressed that the family planning program should provide not just advice on birth control, but also sex and family life education and any other advice that would promote the welfare of the family (Planning Commission 1961: 678, ¶68).

The Shift from Clinics to an Extension Approach

During the 1950s, the family planning program was essentially promoted by social workers and family planning professionals based in urban areas, who were trying to initiate a major program of social engineering without any precedents to follow. They tried to promote the establishment of family planning clinics, where people could obtain advice on contraception. But the clinics, which were set up mainly in urban centers or larger villages, attracted few clients for their services.

The number of family planning clinics increased from 147 at the end of the First Plan (1950–55) to 1,649 at the end of the Second Plan (1956–61). Most of the clinics were government-run, although a few nongovernmental clinics were run by the Family Planning Association of India and other, similar organizations. In addition, family planning services were provided at 2,194 rural and urban medical and health centers. Several sterilization centers were also established. The Third Plan aimed at raising the number of clinics to 8,200 by 1966. The effort was to be guided by the Central and State Family Planning Boards (Planning Commission 1961: 675, ¶60).

The limitations of this approach gradually became evident. In 1955, Frank Notestein, Director of the Office of Population Research at Princeton University, visited India (sponsored by the Population Council) to advise the government on matters related to the family planning program and demographic research. Notestein observed, "Much of the public health approach to family planning envisioned at present can be carried on outside a formal clinic setting—indeed, within the village and home. Therefore, there is now no reason to be concerned about setting up and equipping family planning clinics except in urban areas where more elaborate clinical methods may be used."⁸

In 1963, the Report of the Director of Family Planning (Col. B. L. Raina) for 1962–63 proposed that family planning should be promoted through an extension approach. With this approach, specially trained auxiliary nurse-midwives (now generally called "female health workers") were employed by the primary health centers to visit married women in their homes. The health infrastructure was to be expanded substantially, even though the training facilities were inadequate to meet the needs. The population-related goals were to be promoted through a large band of trained workers, who would also deliver valuable assistance with health care and childbearing to the rural population.

In 1960, R. A. Gopaldaswami asserted that the ultimate objective was to bring about a reduction in the birth rate, but, he said, "no particular target has been specified for the amount of reduction to be effected" nor for "the time within which this reduction is to be secured" (Gopaldaswami 1962: 68). By 1963, the reorganized program was expected to help achieve the goal of lowering the birth rate from an estimated 41–45 per 1,000 population to 25 per 1,000 within ten years. In October 1963, with such an optimistic projection, the Ministry of Health and Family Planning granted financial sanction for the reorganized program, which was to be implemented in phases and completely functioning

by March 1966 (Raina 1988: 70). Col. Raina has confirmed, however, that the clinics were to be "an important second-echelon supporting service in the reorganized program" (Raina 1988: 58).

The Introduction of Method-Specific Targets

In the early 1960s, the range of methods that could be promoted through the family planning program broadened. The United Nations Advisory Mission to India recommended, in 1965, a "reinforced program" and considered the birth rate target of 25 per 1,000 to be achievable by 1973. It emphasized the vigorous promotion of the IUD, an intensified sterilization program, and the promotion of the use of condoms, to be distributed through commercial and other channels (Raina 1988: 70–71).

To achieve these objectives, a major change was made in the approach of the family planning program during 1966–67, the first year of the draft Fourth Plan. In this watershed year, the program became "time-bound" and "target-oriented," and annual targets were fixed for the number of acceptors of different methods of contraception.⁹ Responsibility for achieving the targets set by the central government—on the basis of the desired decline in the birth rate—was in turn passed on to successive lower administrative units such as states, districts, primary health centers, and subcenters and their functionaries. In effect, service providers were assigned quotas of work to be achieved in order to realize the goal of lowering the birth rate and reducing the rate of population growth.

It has been alleged that the introduction of method-specific targets was a contribution of the American management experts sent to India by the Ford Foundation. The targets were seen as essential for evaluating the performance of the program and of the personnel involved in implementing it. However, the targets also led to certain distortions that were not widely recognized for a long time. According to Col. Raina, while the extension approach was supported in principle,

in practice, focus on [the] extension approach faded before it took root. The "target approach" was readily understood. Administrators were familiar with it in other activities and programs in industry and agriculture. The "extension approach" appeared rather elusive with no promise of immediate quantifiable results. The extension approach was overwhelmed by the pre-occupation to achieve "targets." . . . Target setting may be feasible and useful at national and state levels, for planning and monitoring the progress of the program. . . . But to enforce targets with explicit or implicit threat to field workers of punishment for non-achievement is absurd and counter-productive. (Raina 1988: 73)

Nevertheless, the tyranny of targets affected the Indian family planning program for nearly three decades, until their removal in April 1996.

The method-specific targets created special problems when, in the early 1980s, there was an attempt to shift the emphasis of the family planning program from sterilization (mainly tubectomy by this time) to reversible methods

of contraception. Even when the targets for reversible methods were not achieved, the grassroots workers could report that they had been met because it was virtually impossible to verify their reports. The field surveys have consistently reported much lower levels of use of reversible methods than the official data on the number of acceptors of these methods (see e.g. Visaria, Visaria, and Jain 1994). It is most unlikely that the survey respondents were misreporting their behavior. In fact, the family planning workers' reports on target achievement have misinformed policymakers about the progress of the program.

Ambitious Goals, Frustration, and Excessive Pressure to Control Population Growth, 1966–77

The death in 1964 of Prime Minister Nehru, an ardent advocate of both family planning and socioeconomic development planning to eradicate poverty, was followed by a border conflict with Pakistan, two severe droughts during 1965–66 and 1966–67, and a war with Pakistan over Kashmir during August–September 1965. As a result, the Fourth Plan did not start on time. The Indian rupee was devalued in June 1966 and an adjustment period followed. The ensuing period, 1966–69, effectively had annual plans.

The Fourth Plan finally covered the period 1969–74, and it reiterated the crucial role of family planning in improving the quality of life and the low level of per capita availability of food, clothing, housing, employment, and social services. The presumed adverse effect of population growth on the rate of savings and the allocation of savings for capital formation was also explicitly noted in the Fourth Plan.

Since the appearance of the celebrated 1962–63 report of the Director of Family Planning, successive documents of the Ministry of Health and Family Planning, as well as some plan documents, reiterated the unrealistic target of a crude birth rate of 25, to be reached by 1973. Some of the documents merit a detailed review to clarify the oddities of the targeting procedures.

The Draft Fourth Plan, 1966–71. The draft Fourth Plan, 1966–71, was prepared within the context of an estimated population growth rate of 2.4 percent (during 1961–65); this rate would rise further to 2.5 percent during 1966–70. In the absence of dependable data on vital rates, life expectancy at birth was presumed to have risen to 50 years by 1966—that is, by nine years between 1956 and 1966.¹⁰ A further increase was expected with the “all-round improvement in health conditions.” Action on a national scale was considered vital for lowering the population growth rate, which in turn was necessary to fulfill the “objective of attaining socio-economic betterment of the people.” The planners recognized the family planning program as “a key program for the success of the country’s Five-Year Plans of development.” The goal of the national family planning program was a reduction in the birth rate from 40 per 1,000 population (in 1966) to 25 per 1,000 “as expeditiously as possible.”

As its instruments to achieve this ambitious goal, the draft Fourth Plan mentioned not only the 11,474 “official” family planning centers but also the

9,329 centers ("depots") for the distribution of contraceptives, located primarily in rural areas to provide supplies, services, and advice. It also stressed that "the program has all along been integrated with the maternity and child health program. All known methods of contraception are being followed with particular emphasis on the IUCD [IUD]" (introduced during 1965–66).¹¹ What later came to be known as the "cafeteria" and the "MCH" approaches were the key policy initiatives, to be reinforced by the activities of other functionaries involved in the development program.

The draft Fourth Plan also proposed a marked increase in the funds allocated for the family planning program and noted such organizational changes as (1) the redesignation of the Ministry of Health as the Ministry of Health and Family Planning, (2) the creation of a Department of Family Planning with a separate Secretary, (3) the appointment of a Commissioner of Family Planning with regional directors, and (4) the establishment of an autonomous Central Family Planning Institute (which was subsequently merged with the National Institute of Health Administration and Education to become the National Institute of Health and Family Welfare).

While the intention was to promote all methods, the IUD was to be emphasized because of its efficacy, reversibility, and acceptability. The Plan proposed (1) recruiting a large number of female doctors for the program; (2) involving private medical practitioners; and (3) implementing the program on a coordinated basis involving several ministries, including the Ministry of Information and Broadcasting, the block-level staff of the Department of Community Development, and the staff of the Ministries of Education, Local Self-Government, and Social Security, as well as various industrial organizations. The local leadership and voluntary organizations were also to be involved in the program.

The Draft Fourth Plan, 1969–74. As the Fourth Plan could not start according to the original schedule, another draft was prepared for the five-year period 1969–74. The draft Fourth Plan, 1969–74, was based on a projection that envisaged a decline in the rate of population growth from 2.5 percent during 1969–74 to 1.7 percent by 1980–81 and to an average of 1.2 percent during the subsequent 20 years. (The population by the year 2000 was projected at 870 million, based on an assumption that the birth rate would decline from 39 in 1968 to 26 in 1980–81, while the death rate would drop from 14 to 9.)¹²

The overly optimistic projection of a decline of about one-third in the crude birth rate over a 12–13-year period was made on the basis of an active family planning program reported to be "now under way." It was further asserted that "the current program of family planning seeks to achieve a faster rate of reduction of birth rate than implied in these projections." This was necessary because "without a successful effort in this direction, it would be difficult to achieve the degree of acceleration in improvement of living standards implied in our (macro-economic) projections for the period." Its significance for the more distant future was obviously even greater.

The section on family planning was even more sanguine and “proposed to aim at a reduction of the birth rate from 39 per 1,000 to 25 per 1,000 within the next 10–12 years.” The goal for the Fourth Plan period itself was a reduction of 7 points or 20 percent by 1973–74. (The slight discrepancy between the two parts of the draft Fourth Plan, 1969–74, regarding the birth rate of 25 or 26 likely to be achieved by 1980–81 was eliminated in the final Fourth Plan in favor of the more ambitious goal.) It was claimed that, to achieve this goal, a concrete program had been drawn up for creating facilities for the married population to achieve a healthy and happy family by bringing about “(1) group acceptance of the small-sized family, (2) personal knowledge about family planning methods, and (3) ready availability of supplies and services” (Planning Commission 1969a: 310).

Such optimism about the success of the proposed information, education, and communication (IEC) activities of the newly created health infrastructure prevailed, despite the setback in the promotion of the IUD after 1965–66 because of reported side effects like bleeding and pain. It was hoped that these problems with IUD side effects would be overcome because the mechanisms for proper pre-insertion education, check-up, and post-insertion follow-up had reportedly been strengthened. Provision was made for services as well as compensation (or incentive) payments to cover out-of-pocket expenses, transportation to and from the primary health center, and loss of wages for sterilization and IUD insertions. According to the revised draft Fourth Plan, the range of contraceptives offered was to be broadened with the introduction of prescription birth control pills, for supervised use after medical check-up. In addition, the Plan referred to the introduction of injectable contraceptives after medical and other studies had confirmed their safety and efficacy. (Injectables have not been made available even a quarter-century after the possibility was noted, despite the fact that the United States Food and Drug Administration has permitted their use in the US.)

Like the previous draft of the Fourth Plan, the revised draft asserted that the integration of MCH with family planning would raise the effectiveness of the program, and stated that the goal had been achieved—an assertion that seems odd given the fact that, even in 1996, the requisite coordination for integrating maternal and child health and family planning was still considered a goal to be achieved.

The Final Fourth Plan, 1969–74. The final Fourth Plan, 1969–74, retained the thrust of the second draft but revised the projected population estimate for the year 2000 to 890 million. The rate of population growth was expected to decline to 1.0 percent by 2000. Population growth was seen as “a very serious challenge,” calling for “a nation-wide appreciation of the urgency and gravity of the situation. . . . A strong, purposeful Government policy, supported by [an] effective program and adequate resources of finance, men and materials,” was considered “an essential condition of success” (Planning Commission 1969b: 31–32).

The national government had decided to keep family planning as a centrally sponsored scheme, whereby it would meet the entire expenditure for it. Further, it was to be ensured that performance did not lag behind expenditure and that enduring results would be achieved through appropriate education and motivation. The proposed plan outlay for the period 1969–74 was raised from Rs. 3.0 billion to Rs. 3.15 billion (Planning Commission 1969b: 391–395).

During the time frame of the Fourth Plan, the results of the 1971 Census indicated that the average annual rate of population growth during the 1960s (2.2 percent) had been lower than the projected 2.4 percent. At the same time, the estimates of birth and death rates and infant mortality from the Sample Registration System (SRS) confirmed that the pace of decline in fertility and mortality had in fact been slower than projected. The policy goal then became to accelerate the decline in the birth rate by hastening the pace of contraceptive adoption.

The Medical Termination of Pregnancy Act was passed by the Indian Parliament and came into force from April 1972. It permitted abortion of fetuses of up to 20 weeks with the approval of two registered medical practitioners to avoid the risk of "grave injury" to the "physical or mental health" of the pregnant woman. It was a liberal act, even though the available facilities for abortion in rural India continue to be quite poor even 25 years later. The expected introduction of facilities for abortion through vacuum aspiration or suction has not occurred on a significant scale.

In view of the difficulties experienced in promoting the extensive use of IUDs, the family planning program began to emphasize sterilizations through special camps. A mass vasectomy camp was organized in 1971 at Ernakulam in Kerala state under the leadership of an energetic district collector (Mr. Krishna Kumar, who later became the Minister of State for Family Welfare). It offered higher-than-usual incentives to acceptors, and possibly to workers as well, for presiding over 62,000 vasectomy operations in a period of 31 days (see Soni 1971). As other states sought to repeat the Ernakulam performance, the Planning Commission cautioned that the "trend" might "perhaps go against the policy of providing family planning services as part of the health services through an elaborately constructed infrastructure." However, the Commission noted, "in view of the urgency of the problem," it might be "necessary to adopt the camp approach as well" (Planning Commission 1971: 223, ¶22). During the last year of the Fourth Plan, 1973–74, severe inflationary pressures forced a "heavy cut" in "the financial resources allocated for the family planning program," and the mass vasectomy camps were discontinued. Although a substantial part of these funds was later restored, the suspension of the camps led to a "steep fall" in the number of vasectomies performed during the year (Ministry of Health and Family Planning, n.d.). This situation perhaps contributed to the subsequent pressure for moving away from the approaches of a "soft state" (that is, one that does not take hard or harsh actions to implement its policies) that India was considered to be by Gunnar Myrdal.¹³

The outline of the Fifth Plan was prepared in the wake of sharply increased oil prices during 1972–73 and 1973–74. The draft prepared in 1974 could not be given an effective final shape, and during the period of emergency declared by the prime minister in June 1975 (lasting until 1977), much of the decisionmaking regarding development was highly centralized. The Fifth Plan was formally approved by the National Development Council in September 1976. It was to cover the period 1974–79, but in the wake of the 1977 elections, in which Prime Minister Indira Gandhi and her Congress Party were defeated, it was terminated prematurely, in March 1978. The years between 1966 and 1977 marked an unusual time in the history of Indian population policymaking. The Fifth Plan, like the Fourth, noted the difficulties created by the high rate of population growth in terms of the attempts to eradicate poverty.

The Momentous Fifth Plan Period, 1974–78. The draft outline of the Fifth Plan attributed the failure to attain the targeted decline in the birth rate “largely” to “the highly ambitious targets set earlier, coupled with the insufficiency of efforts to project the program, throughout the country, as a mass movement and the rather slow build-up of infrastructure in some of the more populous regions for extension efforts and provision of services.” While recognizing the unfeasibility of the earlier goal of a birth rate of 25 by 1980–81, it proposed a target of a birth rate of 30 by 1979 and 25 by 1983–84.

The primary objective of the Fifth Plan was to integrate family planning with the “minimum needs” program; the goal was “to provide minimum public health facilities integrated with family planning and nutrition for vulnerable groups—children, pregnant women and lactating mothers” (Planning Commission 1974: 234). Implicitly recognizing the weakness of the earlier claim about the integration of different services, the Fifth Plan proposed to “increasingly integrate the family planning services with those for health, MCH and nutrition.” To promote demographic effectiveness (that is, a fall in the birth rate and in the rate of natural increase) and cost-effectiveness, it proposed a selective approach, which involved concentrating some efforts—for example, the provision of more funds to set up more primary health centers or subcenters—in selected districts and setting method-specific targets or segmenting the population of eligible couples according to the number of children.

The two-year period 1975–77 was an important milestone in the implementation and evolution of India’s population policy. It has had an indelible impact on much of the debate about population growth both in India and abroad.

By the early 1970s, Indian expertise on the analysis of population trends and historical experience had become quite strong. Of course, much of the historical experience pertained to a period when fertility decline in industrialized countries had occurred as a consequence of economic development without a state-sponsored family planning program. At the World Population Conference held in Bucharest in 1974, the Indian delegation, led by the Union Minister for Health and Family Planning, Dr. Karan Singh, promoted the view that “devel-

opment" is the "best contraceptive." Within the country, however, rather surprisingly, the official perception changed radically within a year. In 1975, after Prime Minister Indira Gandhi had declared a period of emergency, her son, Sanjay, began to take considerable interest in the promotion of sterilization (primarily vasectomy) to slow the rate of population growth,¹⁴ and the political leadership in general began to show support for the use of stronger measures, including compulsory sterilization. To this end, an active campaign was mounted in the press and the media to support legal action to sterilize couples who already had three or more children. Censorship of the press and a general climate of fear limited the expression of contrary views and created a misleading impression of a consensus in favor of a coercive population policy.

In a statement on population policy tabled in the Parliament in April 1976, Dr. Karan Singh reiterated the government's intention to vigorously pursue many of the measures that were essentially "beyond family planning" policies. These included raising the age at marriage and promoting female literacy and employment. In addition, it attempted to tackle an important political dimension of differential population growth in different parts of a continental country with a federal structure. Political representation in Parliament was determined by a state's population size. Thus, a slower population growth rate in a state could result in a loss of relative influence through a drop in the number of seats in the national Parliament. To safeguard against this possibility, representation in Parliament and in state legislatures was frozen up to the year 2001, according to the population enumerated in the 1971 Census. In addition, all ministries and departments of the central and state governments were to implement plans to motivate couples to undertake "responsible reproductive behavior," and such plans were to be an "integral" part of their programs and budgets. Monetary compensation to acceptors of sterilization was raised and graded according to the number of living children.

Most important, the policy statement also expressed the government's willingness to entertain the possibility of state-level action or legislation for compulsory sterilization under certain conditions. At the height of the overly enthusiastic pursuit of a lower population growth rate, there was widespread talk of "no-birth years" in Maharashtra and of "birth-free years for couples with three children" in Uttar Pradesh (Visaria 1976). Later in 1976, the legislature of Maharashtra state passed a bill providing for the compulsory sterilization of couples with three children.¹⁵ However, following the defeat of Prime Minister Gandhi and her government (which included Dr. Karan Singh), the act was allowed to lapse when the president of India withheld his assent.

In a recent personal discussion, Dr. Karan Singh explained that in 1974, when he called development the best contraceptive, he had not considered it to be the only contraceptive. In fact, in 1992 he proposed a new slogan: "Contraception is the best development." Further, in his opinion, he was able to convince Prime Minister Gandhi about the importance of the population problem; and a general climate in favor of compulsory sterilization had indeed been

created. Some of the state chief ministers had sought his support for such a policy, although only Maharashtra actually passed a law on the subject.

In a preface to the revised edition of his autobiography, Dr. Karan Singh briefly recalls the events of that period. According to him, when Sanjay Gandhi added “family planning” to his erstwhile four-point program, the chief ministers of some North Indian states unilaterally raised their sterilization targets to please the rising star on the political horizon.¹⁶ However, the central Ministry of Health and Family Planning did not raise its targets, and Dr. Karan Singh wrote letters and convened meetings of the state chief ministers and health ministers urging them not to use coercion. While the sterilization figures soared in 1975–76, “the post-emergency backlash threw the program back by a crucial decade,” and “family planning became a dirty word” (Karan Singh 1994: xvi).

According to a Commission of Enquiry set up after the emergency, Dr. Karan Singh wrote to Prime Minister Gandhi in October 1975, saying that “the problem [of rapid population growth] is now so serious that there seems to be no alternative to thinking in terms of [the] introduction of some elements of compulsion in the larger national interest” (Pai Panandiker and Umashanker 1994: 89). The record clearly shows that the earlier concern about family planning as a means of furthering individual welfare and accelerating improvement in the quality of life was replaced by an obsession with speedily lowering the birth rate. The staff members of the family planning and other departments were subjected to considerable pressure to achieve the targets allotted to them. They in turn used their official influence or authority to mobilize people and bring “acceptors” into the sterilization camps.¹⁷ The other departments whose staff were assigned targets included the police as well as agencies involved in the delivery of services and subsidies from the state. These efforts to enforce the sterilization targets created a strong negative public reaction, and many reports of excesses and irregularities continue to rankle in the public memory two decades later.

Gradual Recovery of the Family Planning Program After 1977

For several years after the end of the emergency period in 1977, the Indian family planning program was in the doldrums despite the support it received from the president and the successive prime ministers. Even as late as 1980, the villagers in several parts of the country used to run away to the fields when a government jeep approached the area or when visitors asked how many children they had. It has been difficult to change this situation, and few of the social scientists who have worked on these issues since 1977 have shown the requisite imagination or sagacity to recognize the damage that was done during those years.

The 1977 Policy Statement of the New Government. The government that came to power in 1977 issued a new Population Policy Statement and reaffirmed the entirely voluntary nature of the family welfare (or family planning) program. The government declared itself to be “against any legislation for compulsory sterilization either at the central level or by the States.” It also re-

moved the use of monetary incentives to increase the acceptance of sterilization, although it resolved to continue the pursuit of the earlier policy's other elements, including raising the age at marriage, improving female literacy, and improving the socioeconomic status of women.

The new statement of policy also stressed that the program should promote the immunization of children against DPT and should provide antenatal, natal, and postnatal care to pregnant women. More importantly, it proposed to give equal emphasis to all family planning methods and let families choose their own method of contraception. In addition, employees of the state and national governments, autonomous bodies, local bodies, and so forth were "expected to set an example and to adopt the small family norm" (Ministry of Health and Family Welfare 1978: 173–176).

The number of acceptors of family planning, particularly of vasectomies, declined sharply after 1976–77. The backlash continued for at least three to four years after the emergency had been lifted and the new government had reiterated the noncoercive nature of the program.¹⁸

A Modified Population Policy. The Planning Commission that drafted the Sixth Five-Year Plan for the period 1978–83 set up a Working Group on Population Policy. Its illustrative population projections, prepared under various assumptions about the rise in age at marriage and alternative assumptions about the level and method-mix of contraceptive use, became the basis for population goals included in the subsequent plans as well as the National Health Policy of 1983. Again, wishful thinking dominated the deliberations of the group. The projections were linked to the country's achievement of a net reproduction rate (NRR) of unity—that is, 1. (An NRR of 1 means that a generation of mothers is replaced by an equal number of daughters at the end of their reproductive period, after accounting for the effect of mortality.) The unrealistic goal of achieving an NRR of 1 by 1996 was adopted for the country as a whole and by 2001 for all states. An NRR of 1 was consistent with a birth rate of 22 and a death rate of 9. Correspondingly, infant mortality was to be lowered to below 60 from around 120 during 1977–79, and life expectancy was to rise above 60 years; effective couple protection rate,¹⁹ was to be raised to 60 percent by 1996.

The revised draft of the Sixth Plan, 1978–83, noted that the "climate of coercion and pressure . . . witnessed in some parts of the country during the period of internal emergency in . . . the implementation of the family planning program" had resulted in "an attitude of antipathy and indifference towards the program in the post-emergency period." Nevertheless, the Plan assigned "a very high priority" to the program and stressed the need for motivation, persuasion, and education for the "very difficult and delicate task" and emphasized that "all methods of contraception have to be promoted simultaneously" to encourage "open choice." The Plan outlay for MCH was to be tripled to represent 3.4 percent of the Sixth Plan outlay for family planning (compared with 1.6 percent of the total in the Fifth Plan).²⁰

The goals proposed by the Working Group were incorporated into the final version of the Sixth Plan, 1981–85, drafted by a Planning Commission set up by Mrs. Indira Gandhi, who had returned to power in the 1980 elections. The accentuation of environmental, natural resource, and infrastructure problems as a result of the continuing high rate of population growth was noted in the Sixth Plan. The Plan also recognized the momentum of growth built into the young age distribution of the population. Because of the young age distribution, the number of persons of reproductive age is bound to rise. Even if all these couples have no more than two children each—enough to replace themselves—the population would continue to grow for at least six to seven decades.

The targets for sterilization were increased to curb population growth as early and as quickly as possible. Instead of only annual targets for the users of various contraceptive methods, long-term targets were specified for the NRR and the effective couple protection rate. The instruments for reaching these targets remained essentially unchanged: social pressure was to be applied against early marriages and large families; spacing methods were to be promoted among younger couples; and nongovernmental organizations, social groups such as Mahila Mandals (women's groups), and other organizations engaged in development work were to be involved with family planning and population issues.

The long-term targets for the year 2000 were incorporated in the National Health Policy approved by Parliament in 1983. These targets have, in a sense, guided the program since 1980. The health policy is a more comprehensive document with appropriate references to the issues of maternal and child health, nutrition, and so forth. The actual performance with respect to the promotion of the family planning program has fallen short of the ambitious goals set during the Sixth Plan period and subsequently.

The Seventh Five-Year Plan, 1985–90. The Seventh Five-Year Plan, 1985–90, continued the tradition of optimistic population projections and envisaged a decline in the rate of growth to 1.53 percent during 1996–2001. The NRR of 1, however, was not considered likely to be reached until 2006–11 (Planning Commission 1985: 11). The Plan envisaged better program management; greater emphasis on MCH to reduce infant and child mortality; a program of health care for women, newborns, and young children; an expanded program of immunization; health services for school-age children; and active participation in the program by nongovernmental and community organizations (Planning Commission 1985, vol. 2: 278–287).

A major change in the implementation of the family planning program following 1981 was the effort to promote reversible methods. The reported numbers of acceptors of IUDs, condoms, and oral contraceptives rose faster than ever before. However, considerable evidence has accumulated indicating that the data were manipulated at the grassroots level to create an impression that the prescribed targets for these methods were achieved (Visaria, Visaria, and Jain 1994: 293–303). The Third All-India Survey conducted by the Opera-

tions Research Group in 1989 and the National Family Health Survey conducted during 1992–93, as well as some district-level studies, have confirmed the widespread existence of overreporting. The contraceptive use rate reported by these surveys, particularly for the reversible methods, is markedly below the estimates based on the service statistics compiled by the Department of Family Welfare (Operations Research Group 1990; International Institute for Population Sciences 1995; Visaria, Visaria, and Jain 1995).

The results of the 1991 Census showed only a small decline in the average annual population growth rate during the 1980s compared with the growth rate during the preceding two decades (2.1 versus 2.2 percent, respectively). This nominal decline has often been interpreted as an indication that the family planning program failed to achieve its main objective. However, the growth rate represents the difference between the birth and the death rates and is not really a good indicator of the impact of the family planning program (Visaria and Visaria 1995).

The Eighth Five-Year Plan and Beyond. The Eighth Five-Year Plan, 1992–97, records the fears about the likely aggravation of social tensions and other problems as a result of the continuing high rate of population growth. In 1992, with the decline in the birth rate slower than projected, the members of the Planning Commission for the Eighth Plan had to rethink their goals, and they eventually reconciled themselves to a target period of 2011–16 for reaching an NRR of 1. In the wake of recent evidence of an accelerated fertility decline, there has been an increased willingness to adopt realistic goals and to avoid overly optimistic projections.

The Technical Group appointed by the Planning Commission to prepare population projections for the Ninth Plan period (1997–2002) has avoided the concept of the NRR of 1. Its projections are based, instead, on the fertility and mortality data gathered by the Sample Registration System, focusing on the replacement level of fertility. Its extrapolation of the recent trend in the pace of declining fertility observed during the 1980s and early 1990s indicates that replacement-level fertility is not likely to be achieved in the country as a whole until 2021 and, in some states, not until much later.

Diagnoses of the Difficulties in Lowering Fertility

A strengthening of the training facilities for and academic programs on follow-up services as well as the after-effects of sterilization and the use of other contraceptives was considered necessary in the Third Plan. Resource constraints and staff shortages were recognized as the major problems of the program in the Fourth and succeeding plans as well. The factors contributing to the nonrealization of the population policy goals were identified and discussed with remarkable candor in the Eighth Five-Year Plan, 1992–97. The main points were:

- The program has remained a unisector program of the MOHFW.
- It has suffered on account of centralized planning and target-setting from the top.

— The monitoring mechanism has been reduced to a routine target-reporting exercise, making it impossible to identify problems and/or take corrective action.

— Both initial and on-the-job training are poor and program implementation is ineffective and insensitive—ineffective insofar as it has not really persuaded many young couples to accept or practice family planning, and insensitive to both the problems of women who want children and are unable to have them, and to the difficulties faced by health workers in their task(s).

— The program has remained a government initiative; active community involvement is marginal.

— The IEC activities have been directed more to national than to personal issues. Workers often talk to couples about the total increase in the country's or state's population and not about the problems that a family is likely to face, for example, the increase in the subdivision of landholdings and the like.

— The program suffers from overreporting contraceptive use rates, neglect of reversible contraceptive methods, and few or no MCH activities.

The Eighth Plan, therefore, proposed an integrated approach to family planning and concerted efforts through both governmental and nongovernmental organizations, besides social and political commitment to make slower population growth (through a reduction in the fertility rate) a national goal. The Plan proposed a decentralized approach, consistent with the recent constitutional amendments relating to the introduction of a system of *panchayati raj*—local self-governing councils elected for groups of villages, blocks, and districts to help “decentralize” the government.

The current climate in India is favorable in several ways to a revamping of the country's population policy and family planning program. Before noting them, however, we discuss the recent initiative for a new National Population Policy.

The Quest for a National Population Policy

After the 1991 Census, the Karunakaran Committee of the National Development Council (NDC) proposed the formulation of a National Population Policy.²¹ The policy was to take “a long-term holistic view of development, population growth and environmental protection” and suggest “policies and guidelines [for] formulation of programs” and “a monitoring mechanism with short, medium and long-term perspectives and goals” (Planning Commission 1992). The proposal implies an interesting position about the earlier population policy statements of 1976 and 1977. It has been argued that while the earlier statements were placed on the table, Parliament never really discussed or adopted them. In August 1993 an expert group headed by Dr. M. S. Swaminathan was asked to prepare a draft of a national population policy that would be discussed by the Cabinet and then by the Parliament. The draft, submitted in May 1994, was subsequently circulated among the members of Parliament, and various agencies of the central and state governments were asked to comment. While a national population policy approved by the National De-

velopment Council and the Parliament was initially expected to help produce a broad political consensus, this does not seem to have happened. However, in his address to the nation on the 50th anniversary of India's Independence, Prime Minister I. K. Gujaral has promised to announce a National Population Policy in the near future.

The government has begun to reorient the family planning program in light of some of the policy proposals of the Karunakaran Committee, the Expert Group chaired by Dr. Swaminathan, and the concerns articulated in the Program of Action approved at the International Conference on Population and Development held in Cairo in September 1994. It has initiated action to place the issues of reproductive health and gender equity at the center of the family planning program.

Method-specific contraceptive targets were removed effective 1 April 1996.²² At least in theory, a climate has been created in which female health workers can focus their attention on the health and welfare of mothers and children or on the broadly defined reproductive health of the entire population. The state governments have been given the freedom to introduce incentives to the district or lower-level bodies or NGOs for improving the quality of services. There is, however, a concern that the removal of country-wide targets will lead, at least initially, to a decline in performance. The critical question is whether the new system will enable grassroots workers to undertake a "real needs assessment" in consultation with the communities they seek to serve and whether it will eventually lead to the development of plans and operational strategies from the ground up, to guarantee the health and welfare of millions of individuals and families (Ministry of Health and Family Welfare 1996: 1-2). Consultations with field workers in different parts of the country have indicated widespread disappointment with the needs-assessment forms in the new manual prepared by the government.²³ The cost and benefits of these exercises need to be researched carefully over the next few years.

There is widespread skepticism about the likely duration of the new policy, and many program managers do not understand the manner in which the new system is expected to function. As a result, in some states the new system has reportedly led to even more ambitious targets than were set during the period of centralized decisionmaking. The Indian system shows a surprising resistance to any proposal for modifying the accepted past approach to performance monitoring and evaluation. It is quite likely that these stresses and strains will continue while the country's fertility and mortality rates progressively decline and the need for targets becomes insignificant (as has happened in Kerala and Tamil Nadu). The national policymakers have a critical role to play in convincing their colleagues in the states of the need to concentrate on the replacement level of fertility rather than on levels of contraceptive acceptance.

Several factors are favorable to an effective reformulation of population policy: the evidence of an extensive and considerable decline both in fertility and in infant and child mortality; the rise in levels of female literacy and school

attendance rates and the ongoing campaign to promote total literacy; and the spread of the mass media, which can play an important role in IEC activities and in training female health workers. The rising immunization rates and the proposed nationwide activities of the Integrated Child Development Services open up possibilities of a concerted attack on prevailing levels of malnutrition and anemia.²⁴

For the first time, the effective implementation of many of the original population policy's goals, and those recommended in successive five-year plans, seems possible—including the integration of MCH and family planning activities. However, if this possibility is to become a reality, a candid appraisal of the problem areas is necessary. These areas include (1) the existence of dissent from the official population policy; (2) the difficulties in implementing "beyond family planning" policies and an effective IEC program; (3) sources of opposition to population policy; (4) the alienation of some Indian feminists from the family planning program; and (5) the role of external advisers in the formulation and implementation of Indian population policy. We examine each of these issues in turn.

Popular Perceptions of Population Policy. The Indian family planning program has faced difficulties in winning the confidence of the people, in part because social scientists and other researchers have paid insufficient attention to the public's perceptions about population growth. At the same time, the people at large do not understand the abstract reasoning of social scientists and policymakers, in part because family size is, for them, an individual, private matter. This means that intensified IEC efforts are needed to accelerate the pace of recognition by the people of the consequences of population growth or the externalities of individual behavior.

Of course, the people have also recognized the consequences of population growth for the size of landholdings available to them for cultivation (Visaria and Visaria 1996: 13–15). However, this recognition is moderated by the possibilities of outmigration and by the scope for nonfarm work opportunities even without moving to a town or city. These possibilities can limit the interest of local *Panchayats* in restricting the family size of their residents. Overall, people in most parts of the country have responded positively to the family planning program and have taken advantage of the facilities or services offered, so that fertility is now dropping at a rate faster than seemed feasible until the mid-1980s. Now, intensified efforts are needed to better understand the motivations regarding family size and fertility among various segments of the population.

"Beyond Family Planning" Policies. As noted above, the need for a broad approach to population issues was clearly identified in the Third and subsequent Five-Year Plans. The oft-repeated measures include the need to improve the socioeconomic status and literacy rates of women. Many of the plans have emphasized the need to promote family life education, to place more emphasis on MCH, and to raise the age at marriage of girls, which is now quite low. The singulate mean age at marriage for the country as a whole, according to the

1991 Census, is about 19.6 years. The figures for Kerala and Tamil Nadu are reported to be 23.9 and 21.3 years, respectively. However, estimates for the four large Northern states of Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh and for Andhra Pradesh range between 17.6 and 18.4 years—about 5 to 6 years lower than in Kerala. Progress on all these issues has been slower than anticipated because of the inherent difficulty of social engineering in a large complex society under a democratic government. The government has few instruments available to influence the intra-household behavior of the people and to alter it in favor of a different set of values.

Many proposals to raise the status of Indian women have stressed raising the number of productive employment opportunities. Since women in rural India already perform unpaid work on family farms or in other family enterprises, the reference has been to paid work or jobs outside the home. Most of these proposals have overrated the government's capacity to "create" a substantial number of employment opportunities and, further, to assign them to particular groups of the population in different parts of the country. The problem has been serious throughout the past 45 years of planning for economic development, but the constraints on state action are even more severe today because pressures to contain public expenditure and reduce fiscal deficit have led to a decline in the level of public investment.

Sources of Opposition to Population Policy. The Indian planners' adoption in the 1950s of a policy to promote the family planning program was possible partly because of the absence of any well-organized religious opposition to birth control. However, within the ranks of the Congress Party, which formed the central government continuously from 1947 until 1977, there were different strands of thought, represented by the ardent followers of Mahatma Gandhi as well as the socialists and the Marxists, who tended to be pronatalist.

During the 1950s and the 1960s, as observed earlier, there was some dissent from the official policy among Gandhi's "constructive" followers and among the leftist political parties,²⁵ which were guided by Marxist philosophy and did not regard population growth as a problem in terms of a negative impact on the economy. Their views changed only gradually as the population of India continued to grow at an average annual rate of more than 2.2 percent up to 1981. Indian policymakers and political leaders were also influenced by China's success in lowering fertility and its rate of population growth after 1978.

Another source of opposition to the official policy to promote family planning and lower fertility has been the widespread perception that Muslims in India were not accepting contraception and that the rate of growth of their population continued to be higher than that of other groups. This concern is based partly on the unpleasant memories of India's partition in 1947 in the name of religions professed by the people in the areas that now form Pakistan and Bangladesh. The higher rate of growth of the Muslim population during successive intercensal periods strengthened this concern. Many Indians fear a second partition of the country or a situation in which the Muslims would constitute a majority of the population, particularly in some districts and states

sharing a border with Bangladesh or Pakistan. Yet, they overlook the fact that the high Muslim fertility is at least partly a correlate of their lower levels of literacy and education and their concentration in states where non-Muslims also have a higher level of fertility than the national average. There is also evidence that the practice of contraception, including the use of nonreversible methods, has continued to rise among Muslims (Visaria and Visaria 1995).

Some believe that an element of compulsion needs to be reintroduced in the Indian family planning program in order to minimize the differences in contraceptive use among the main religious groups. The advocates of this view seek a revival of the policy adopted during the emergency period of 1975–77 to compel persons with more than a specified number of children (usually three) to undergo sterilization.

India's Feminists and the Family Planning Program. In recent years, the women's movement has been split in its attitude toward the Indian family planning program, mainly concerning the introduction of hormonal methods of contraception and the introduction of disincentives such as the proposal to limit maternity leave to pregnant women with no more than two children.

From the 1950s, Indian policymakers have been cautious about introducing different methods of contraception in the family planning program. Various contraceptives such as foam tablets, spermicidal jellies, the IUD, birth control pills, and hormone-based methods including injectables and Norplant® were to be tested in experimental trials conducted under the auspices of the Indian Council of Medical Research for their suitability for adoption in India. The poor nutritional situation and the widespread practice of prolonged lactation in India might produce contraceptive side effects that are not a problem in industrialized countries. As a result, the testing and screening processes have been quite slow. Moreover, the medical scientists in charge of the trials have sometimes been criticized—by, among others, some of India's feminists—for yielding to pressure from donor agencies or from the multinational (mainly American) firms manufacturing and distributing particular products. It is difficult to confirm whether and how far the suspicions are justified, but the need for proper ethical procedures is obvious and a credible system for monitoring contraceptive trials needs to be put in place.

While India's feminists support the right of women to limit their family size in the interest of their health and independence, they are aggrieved by the poor quality of the services provided to women undergoing sterilization or accepting other methods. Their criticism of so-called demographic fundamentalism²⁶ is sometimes misplaced but it is born of a fear that many decisionmakers are too obsessed with reducing population growth to worry about the adverse consequences of contraceptives on women's health. Their distrust of provider-controlled contraceptives is generally justifiable considering India's high levels of illiteracy and poverty, which limit most women's ability to ask for and obtain correct information and adequate care. Nevertheless, feminists often show a surprising inability to discriminate between policymakers and other professionals and to identify their potential allies. Undue reliance on se-

lective evidence and outdated dogma also limits their ability to enter into a dialogue with policymakers and to win their support for improving the lives of Indian women.

The External Influence on India's Population Policy and Family Planning Program. Contrary to the widespread belief that India's population-related programs receive extensive external funding, international assistance in the field of population was largely in the form of technical assistance prior to 1972–73. During the Fifth Plan period (1974–79), external assistance covered about 16 percent of total expenditures on the family planning program. The share dropped to around 14 or 15 percent during the Sixth (1980–85) and Seventh (1985–90) Plan periods. The absolute amounts of foreign funds transferred to India have risen partly because of the devaluation of the Indian rupee over the years. Between 1990 and 1993, the share of foreign aid spent on the Indian family planning program rose to 23 percent, partly because of a USAID-assisted project on innovations in the family planning program in the state of Uttar Pradesh. A significant part of the external funds that India has received has been used to construct primary health centers and subcenters; some effort has also been made to use these funds for training activities. On the whole, however, the Indian family planning program has been funded primarily from internal resources.

We noted earlier that India's expatriate advisers warned the government not to depend on clinics for the promotion of family planning in rural areas, and stressed the importance of strengthening the family planning data base and research capabilities. In addition, around the time of the Second Five-Year Plan, the work of Ansley Coale and Edgar Hoover alerted Indian planners and policymakers to the possibility of a sharply accelerated population growth rate because of an unexpectedly rapid decline in death rates, such as had reportedly occurred in neighboring Ceylon (Sri Lanka).²⁷ The caveat was later confirmed by the 1958–59 National Sample Survey, which indicated that the rate of natural increase in rural India had already risen to 1.9 percent during 1958–59. Yet, the planners were not prepared for the results of the 1961 Census, which indicated a total population of 439 million (instead of 404 million) and an average annual intercensal rate of growth on the order of 2 percent.

Because of their expertise with management information systems, outside advisers have probably played a vital role with respect to the introduction of method-specific targets in India's family planning program. These advisers were not able to recognize the Indian capacity for only a nominal fulfillment of the prescribed system, while its spirit or essence was violated. As a result, the Indian program has not been able to get the expected benefit from the considerable investment of effort and time in the process.

Also, rather surprisingly, the excessive zeal of policymakers during the emergency era to slow the rate of population growth did not raise any noteworthy international criticism. Advisers from the industrialized countries looked at the surprising developments in the Indian family planning program with a sense of awe and possibly even covert admiration.²⁸ Few of them ad-

vised the government of India that only a highly developed state has the capacity to shape the behavior of its citizens in such personal matters, or that a state that cannot enforce compulsory primary education for children up to age 14 lacked the capacity to sterilize couples with three or more children²⁹ (Visaria and Jain 1976).

At another level, in the late 1960s and the 1970s, particularly after the devaluation of the Indian rupee in 1966 and the rise in oil prices, the Indian balance of payments became difficult. The role of the Aid India consortium led by the World Bank was to decide the amount of annual foreign assistance to India that was vital for the Indian economy. Each year, the memorandum on the performance and prospects of the Indian economy sought to monitor and report to the donor governments India's efforts to lower its rate of population growth. The data on annual acceptors of different methods of contraception were not readily available to Indian scholars at the time but they were routinely supplied to the World Bank, and through it to other government donors. It is likely that these monitoring requirements created pressure to accelerate the pace of progress toward reducing the birth rate and contributed to the movement to introduce compulsory sterilization in the Indian family planning program.

Similarly, the criticism that the Indian program relied solely on sterilization probably contributed to the later efforts to promote reversible methods. However, neither the health workers nor the senior staff have genuinely changed their approach, so reversible methods are still not widely used. Moreover, there is some resistance to the use of these methods, which is in part due to the fact that contraceptive supplies are not regularly available in villages (600,000 of them). Also, information about and supplies of oral contraceptives and the diaphragm are not readily available. The Indian genius for satisfying the advisers without really changing the situation at the grassroots level has restricted the usefulness of service statistics as a means of assessing the performance of the family planning program.

THE PUBLIC PERCEPTION OF POPULATION ISSUES

Although nearly five decades have elapsed since the initiation of the family planning program in India, relatively little is known about the extent to which the people share the planners' and policymakers' concerns about the impact of population growth on their living standards. In the early 1950s and 1960s, when India's population policy was still evolving, surveys were conducted about the knowledge of, attitudes toward, and practice of family planning methods. Most of these KAP surveys, as they are called, indicated that people were generally willing to limit their family size to a smaller number than the children ever born to them. Rather surprisingly, the literature is largely silent about the fact that, when respondents report on their desired number of children, they are talking about the number of living children they want to have rather than the number of births of children. In effect, the gap between the data on desired family size and the number of children ever born to couples reflected, in part, the effect of high mortality among infants and children.

Recent efforts have focused on the public's perceptions of the population problem and on the extent to which they recognize its impact on their living standards. During an intensive four-district survey of 13,200 households in Gujarat, conducted in 1989, respondents were asked whether during the previous decade the living conditions in their village or town generally and in their own household specifically had improved, deteriorated, or remained the same. A similar survey of 3,000 households was conducted during 1991 in three districts of Kerala.

The main respondents were married women of reproductive age. The educational attainment of the head of the household or of the respondent's spouse was noted. The rate of nonresponse (answered "I don't know") was between 1 and 11 percent for the Gujarat survey, and 17–18 percent in the Kerala survey.

Changes in the Living Conditions of Villages or Towns

A large majority of the respondents in both Kerala and Gujarat reported that the schooling facilities, transportation, and health care facilities, as well as maternal and infant mortality, had improved over the ten years preceding the survey. However, in Gujarat about 56 percent of the rural and 68 percent of the urban respondents reported a decline in the average life span, which probably means that the question was not understood properly.

An interesting difference between Gujarat and Kerala concerns changes in the opportunities for employment. Nearly 42 percent of those who answered this question in Kerala reported that the employment situation had gotten worse. The corresponding figure for Gujarat was just about half as high. More important, a much higher proportion of the better-educated respondents in Kerala reported a deteriorating employment situation than the less-educated respondents. In Gujarat, on the other hand, the corresponding differences were much smaller between those two groups. Also, a higher proportion of the literate and better-educated respondents in rural Gujarat reported an improvement in the availability of work or employment opportunities, while in urban areas the observed differences according to educational attainment were small. The data have captured very well the acute paucity of work opportunities for the better-educated in Kerala State, which also had the country's second highest population density in 1991. Moreover, until about 1971, the population growth rate in Kerala exceeded the national average, which resulted in a faster rise in density and an increase in pressure of population on land and in the labor market. The concern about work opportunities has contributed both to the rise in the age at marriage and to the fall in marital fertility in Kerala.

Changes in the Condition of Respondents' Households

In Gujarat, over 38 percent of the households reported an improvement in their economic status; about 48 percent reported no change; and only 13–14 percent reported a deterioration during the previous decade. (This question was not included in the Kerala survey.) Those who reported an improvement in living conditions in Gujarat attributed it to good agriculture (in rural areas), to good

business conditions (in urban areas), to a son's employment, or to the respondent's promotion at work. The reported reasons for a deteriorating family situation were more varied, but they included bad agriculture, bad business conditions, a son's inability to get work, the absence of an income-earner, or the loss of a job. The importance of employment is again obvious.

In both states, the proportion of respondents reporting improved living conditions rose with the educational attainment of the head of the household. A rural-urban distinction is not relevant to Kerala, but in Gujarat the results were broadly similar in both rural and urban areas.

Implications of the Findings

These findings are not surprising. A few years ago, a panel of social scientists meeting with the Indian Planning Commission was asked to prepare a note for the prime minister on the adverse implications of the current rate of population growth, in order to persuade him to support a stronger population control effort. It was immediately pointed out that it would be virtually impossible to find any variable with respect to living conditions that had not improved since Independence. (One exception is the growth of urban slums, which have in some sense lowered the quality of living among the better-off residents of towns and cities. But even the slum residents report that they are better off relative to their living conditions several decades earlier.)

The Gujarat study also indicated that over 90 percent of both rural and urban respondents recognized population growth in the area where they lived but over 60 percent of those in rural areas and nearly half of those in urban areas did not recognize the effect of population growth on living conditions. Educational attainment of the head of the household did not make any difference to the pattern of responses. Even in Kerala, where the level of fertility has declined sharply since the 1970s, only 72 percent of the respondents reported population growth in their area (village or town); and more important, only two-thirds of all respondents recognized the effect of population growth on their living conditions.

The central point for reflection is that the Indian people do not perceive the continuing growth of population as adversely affecting their living conditions. Yet, it is also likely that living conditions would have improved faster if population growth had been slower. The recent rapid growth of communications technology and the spread of the mass media have almost certainly broadened the awareness of the people, even in the countryside, about the alternatives open to them. In areas that have witnessed international migration, the improved living standards of the families of emigrants or of return migrants have provided proof that poverty is escapable and living standards can improve—even in the face of continued population growth.

The gap between current living standards and the desire for upward social and economic mobility has been an important factor underlying the acceleration of India's fertility decline. This point came up repeatedly in the focus

group discussions conducted in two of the four surveyed districts of Gujarat and in several villages of Tamil Nadu, where fertility declined sharply during the 1980s and has continued to decline since then. (The TFR in Tamil Nadu, according to the SRS, is estimated to have declined from 3.3 in the early 1980s to 2.1 in 1993.) To some extent, the accelerated pace of fertility decline during the 1980s and early 1990s in most states of India seems to be a result of inflation. That is, constrained finances and the gap between aspirations and the realized level of living have led to higher age at marriage and fewer children. The process is likely to continue in the years ahead.

VIEWS OF POPULATION GROWTH AMONG SENIOR PROGRAM FUNCTIONARIES AND POLITICIANS

During the first half of 1994, personal interviews were conducted by the authors of this chapter with 20 family planning program functionaries and politicians in the states of Gujarat, Madhya Pradesh, and New Delhi. This section presents their diverse viewpoints.

The interviewees were selected bureaucrats and social and political workers who have been key actors in the formulation and modification of population policy and, more importantly, in the implementation of the family planning program today. They were considered influential persons in (1) Gujarat, the second most urbanized and industrialized state, with a reputation for efficient administration; (2) Madhya Pradesh, where a large proportion of the tribal population lives and where mortality and fertility are high; and (3) New Delhi, the seat of the central government.

Gujarat has done fairly well in lowering its population growth rate during the past intercensal decade, 1981–91. Madhya Pradesh has the largest land area and is well endowed with forests and minerals, but it is one of the least developed states of India.³⁰ The interviews were conducted in these two states to gain a balanced overall picture. We have also drawn on informal meetings with senior bureaucrats from the central government and a former Minister of Health and Family Planning, as well as informal discussions with several retired and currently employed bureaucrats and with over 40 social scientists. In total, over 60 people were consulted.

An attempt is made here to highlight the views and concerns of our respondents that shed light on the diversity of opinions held by members of different constituencies on this subject. The obstacles to a radical reorientation of the current approach to population growth and family planning are also highlighted. With free English translation and some comments, the responses are recorded verbatim.

Policy Framework

The Population Problem. All interviews began with questions about the respondent's perception of the population problem. All respondents exhibited some reluctance to take an independent position, but their responses can be

broken down into three general groups. A majority of the answers obtained, especially in the case of service providers, equated the country's population problems with the difficulties of implementing an effective family welfare program. Evidently, their perceptions (reported below) about the population problem were influenced by media reports and by information given out by the government. A second group of respondents mostly restated the official viewpoint while a third group highlighted the deficiencies in the government's official statement of the problem.

The Western Influence on the Indian Approach. Some of the respondents held that there has been no original thinking on the population problem in India, whereas Western thought has had a heavy influence. The problem has been defined as the government's need to keep in view the requirements of the international donor agencies, which have had readily available funds for India's family planning program.

The view expressed by some of our respondents regarding the influence of the West was similar to the views of the Marxists (or leftists) and the workers engaged in the "constructive programme" started by Gandhiji and his close followers in India. They supported the Russian policy of permitting free abortions as a means of improving the status of women, and with the effective implementation of China's "one child per family" policy, most of the leftist opposition to the government's promotion of contraception has subsided. At the same time, the responses indicated that some sort of consensus has emerged that the Indian population growth rate is high and the size of the population is too large to be sustained by the country's limited resources.

The Fear of Religious Discrimination. Some respondents suspected a religious bias in the official approach to the population problem. They alleged that the official policy is implemented in a manner that would check the growth of the Hindu majority but would not affect the minority religious groups, especially Muslims.

The orthodox Hindus are sympathetic to a non-Congress opposition party's concern with reestablishing a preeminent position for Hinduism and its religious preachings in India. They have considerable appeal among the less educated as well as middle-class Hindus, who fear another partition of the country if the minority community becomes numerically more important in certain parts of the country, particularly in the states sharing a border with Pakistan or Bangladesh.

Awareness of the Momentum of Population Growth. Only one of the respondents commented on the age structure of the population and its built-in momentum for growth. He also mentioned rural-to-urban migration as contributing to the problem of slums in urban areas. Many respondents thought only of the birth rate and considered it to be high; it formed the core of the population problem according to most. Very few respondents recognized the vital role of mortality decline in the Indian population problem. A senior officer of the central government noted, however, that the success of policies to lower mortality had created the population problem.

The Family Welfare Program and the Centrally Imposed Population Policy. Most of the service providers did not distinguish between population policy and the family welfare program. Therefore, the comments on the policy were either mixed with the comments on the program or involved criticisms of the latter.

According to a retired senior bureaucrat, the policy is marked by despondency rather than hope. Forced upon the people without adequate research into the problem, and inconsistently applied, it became a coercive structure rather than an organic solution that should have grown from within. It is based, he said, on sectoral thinking—that is, from a narrow perspective.

Some respondents also suggested that the central government failed to consult the state governments in formulating the population policy. No consideration has been given to the regional dimension of the population problem. One respondent even went so far as to say that the population policy has made healthy people sick by forcing them to undergo sterilization. Given the manner in which the policy is implemented, it encroaches upon an individual's freedom. Some respondents alleged coercion even today.

Political Will. Policy formulation is a political activity, and since the family planning program is government-run, political support can influence its performance to a large extent. Political will can also be instrumental in changing social norms. In India, the family planning program was initiated because of the convictions of the highest-level political leadership and the society's elite. However, the decisive and negative public response to the activities during the emergency period has created a deep-seated fear in the minds of most politicians with regard to family planning. The allegations of coercion, for example, were instrumental in the defeat of Indira Gandhi's party in the Parliamentary elections in 1977.³¹ India's politicians today do not want to risk a similar demise by pushing family planning too strongly.

Some of the respondents also expressed the view that today's politicians are interested only in retaining their seats at any cost. Instead of being interested in the formulation of policies and the performance of programs to benefit the people, politicians are mostly concerned with the transfers and postings of personnel, and they tend to interfere in the workings of the ministry and department in this respect.

Other respondents argued that politicians are not committed to any national objective. Therefore, no strong political action is taken to deal with the population problem. Even earlier, said some respondents, the family planning program received political support because international agencies were ready to donate large amounts of money and technical support for population control programs—and the larger the sum of money that any government department got from international donor agencies, the better was its position. In fact, however, the family planning program received little international aid until the early 1970s, so this allegation lacks an empirical basis, although it is a widespread perception.

Empowerment of Women. Almost half (10) of the respondents noted that women do not have an equal say with men in deciding the size of their fami-

lies. Since the family welfare program is aimed more directly at women than at men, its success will depend largely on the empowerment of women. Most of the respondents agreed that there is an urgent need to empower women to allow them to play a significant role in decisionmaking about the family. Along with education, women need skills that will enable them to earn an independent income. As an immediate measure, the government program could provide financial assistance for mothers and daughters so they are no longer considered an economic burden on the family; with economic power, their status in the family and in society will improve.

Suggestions Regarding Policy. As noted above, most of the respondents, particularly those concerned with the provision of services, did not distinguish between the family welfare program and population policy. Five respondents did not offer any comments about the changes necessary in regard to population policy but they gave the following suggestions about the family welfare program:

- The most important change needed is to define the population problem in such a way that the program does a better job of incorporating people's perceptions of the problem. The link between the micro-level and macro-level aspects of the problem should be clear. The link between infant mortality and fertility needs to be emphasized, and local situations should be used to elucidate the problem.

- The formulation of policy must give due consideration to area-specific problems, and should have closer links with other developmental efforts, especially education.

- Recognition of the population problem must be incorporated into the programs of every government department, and all government employees must be involved in IEC work. Population activities should be integrated at least with the general health delivery system and, if possible, with the programs for eradicating poverty and illiteracy.

- The policy needs a more humane formulation with an emphasis on the health of mothers, children, and entire households instead of its present concentration on reducing the population growth rate.

The Fertility Decline versus the Mortality Decline

Although India's fertility level has declined since the 1970s, it has not declined as dramatically as the mortality rate. The reduced mortality rate has been easier to achieve in part because people tend to follow advice about behavior changes required for better health, but hesitate to accept advice relating to the adoption of contraception. The following reasons were cited.

It is generally recognized that the Indian population is too large to allow everybody to lead a comfortable life. But people feel that the government should address this problem. For example, some feel that the government should "reward" people for accepting contraception by providing acceptors with total health care. They also feel that the government should ensure that all

contraceptive services, including surgical procedures, are easily accessible—either by situating them near people's homes or by providing transportation to and from facilities. Furthermore, the government should extend preferential treatment to all family planning acceptors in the provision of all services or subsidies.

Another reason for the relatively slower decline in fertility is that children in India are considered an economic asset, not a burden.³² People feel that they take care of their children and the government does not help them in this respect. Unsolicited government advice about contraception is often viewed as an attack on personal freedom and an invasion of privacy. Nonetheless, the service providers we interviewed (especially in Madhya Pradesh) held that the social norms regarding the ideal family size have changed in India. Many people today do not want to have more than three children, after which they tend to come forward voluntarily for contraception (presumably sterilization), except for certain isolated, less educated groups (indigenous tribes, slum dwellers).

Even though female sterilization has become the primary means of contraception in India, people are generally afraid of surgery of any kind, and they view even IUD insertions as surgery. In addition, quite often the field workers and doctors at the primary health centers are not available during emergencies, and people do not find the program reliable. The government still has not addressed these problems, which clearly have a negative impact on contraceptive use. In addition, people distrust the family planning program, just as they tend to distrust any other government program. Part of this distrust also springs from a general feeling that field workers are interested only in meeting targets in order to earn promotions, not in helping potential acceptors. Our interviewees believe that once people understand that too many closely spaced births endanger the lives of their children, they will accept contraception more readily.

Among Muslims and other minority groups, the topic of family planning is still not discussed openly. People are afraid that if they speak openly in favor of contraception, they will be ostracized. Even those who want to avail themselves of family planning services do so clandestinely, and many women are afraid to tell their husbands that they are using contraceptives.

Finally, according to some interviewees, the state governments do not pursue the family planning program as vigorously as they pursue other programs because the funds for family planning activities are assured, coming as they do from the central government. Funds for other programs such as education have to be raised by the state government, and they take more care to ensure that work is properly done because they are paying for it out of their state budget.

Program Implementation

Cessation of Childbearing Through Nonreversible Contraception. According to the interview findings, the majority of family planning acceptors in India use ster-

ilization once they have achieved their desired family size.³³ The relative popularity of sterilization stems from the fact that it was the first method to be made available under the official program and was promoted as the most dependable. Moreover, surgical procedures are accepted as an integral part of the Western allopathic system of health care delivery and they encounter the least resistance from a large majority of the people. Service providers also favor sterilization because it eliminates the need for continuous follow-up. The main shift has been from male sterilization to female sterilization after the emergency period. Among the various types of female sterilization procedures, minilaparotomy and laparoscopy are preferred over the traditional tubal ligation, mainly because women undergoing a minilaparotomy or laparoscopy need to spend only one day away from their homes, whereas after a tubectomy they must be hospitalized for nearly a week.

Birth Spacing Through Reversible Contraception. Many people in India, particularly in rural areas, do not understand the connection between a longer interbirth interval and child health and survival. Moreover, most of the interbirth intervals in India are fairly long (about 2 to 3 years) due to the almost universal practice and prolonged duration of breastfeeding. Nonetheless, for those women who do not want to become pregnant, said some of our interviewees, an "advantage" of spacing methods is that they can be adopted without the husband's knowledge. Their disadvantages, according to our respondents, include side effects, inadequate patient information, and untrained providers dispensing methods (mainly IUDs and birth control pills) about which they know little.

The side effects of IUDs, for example, make them very unpopular. Our interviewees said that women who accept IUDs are often not given complete information and follow-up is usually inadequate. Moreover, sometimes an IUD is inserted without a proper check-up to identify possible contraindications, and service providers are often not skilled enough to insert IUDs properly.

Birth control pills also have problems. Women who use oral contraceptives often forget to take their pills every day, and they are not told what to do in that instance. As is true for IUD acceptors, women who accept the pill often do not receive an adequate check-up first, and they do not know what to do if they develop side effects.

With regard to spacing methods in general, our respondents said, regular supplies are difficult to maintain in the rural primary health centers and subcenters because the population is so widely dispersed. People often have to walk long distances to the subcenters, and if the field worker is not available they are not able to get the supplies they need.

Female service providers, including doctors, are often unable to communicate with men, according to our interview findings. As a result, they cannot disseminate information about condoms among men. Lack of communication between spouses also leads to incorrect use and method failure, which, again, creates a distrust of the method.

During the past few years, there has been an extensive debate in India about the acceptability of hormonal methods of contraception. Indian feminist organizations are opposed to the use of both Depo-Provera and Norplant, as they are to any technology that might be considered a provider-controlled method of birth control. Their fears are justified in light of the inadequacies of India's family planning program. However, many social scientists and administrators—our interviewees among them—feel that feminists do not really represent the people whose interests they claim to be protecting, and that Indian women need better methods of contraception than are presently offered through the family planning program. Unfortunately, the dialogue between the feminists and mainstream social scientists is often unproductive. Several well-conducted studies on the demand for, acceptability of, and side effects of hormonal contraception are certainly warranted.

Incentives. Cash incentives were given to acceptors of sterilization operations almost from the beginning of the program in the late 1950s, primarily to compensate for loss of wages. The amount of incentive money changed from time to time, and additional gifts in kind were also given occasionally. The gifts differed from place to place, depended mostly on local support, and were not part of the centrally financed scheme. The payment of incentive money was later extended to IUD acceptors and to motivators.

People considered incentives as a reward given by the government for accepting contraception and helping the country to solve its problem of high population growth. Motivators and field workers used the incentives to lure people from the poorer sections of society to accept contraception, usually without giving them enough information to understand the full implications of their decisions. Incentives have also generated corrupt practices, with the motivators sometimes pocketing the incentive money if the client was ignorant. Government employees have also been accused of taking part of clients' incentive money and saying that they had spent it on medicine for the clients. On the other hand, because of the frequently changing rules regarding incentive payments, field workers have complained that they have to pay partly from their own salary to add to the officially prescribed incentive in order to fulfill their targets, although the frequency of such contributions could not be established.

Three of the 18 respondents (service providers) said that the incentive money does not help the program because, they believe, the clients neither understand its compensatory nature nor are motivated to accept contraception just for this money. If no incentive money is paid, these respondents maintained, the program would continue to run as it did before. Three other respondents, also service providers, supported the payment of incentive money in its present form. They argued that for poor acceptors, even a small incentive means a lot, as it can be used to buy several days' worth of food. If the payment is stopped altogether, they said, people will not participate in the program, which would be more disastrous than the continued burden on the government exchequer.

Targets. Annual fixed targets for all methods, imposed from the top down, are set for family planning workers at all levels, and their performance is judged in terms of the fulfillment of the target. The pressure to achieve the targets starts at the top and works its way down to the field worker, who ultimately bears the brunt of the challenge. No excuses are accepted when targets are not achieved, and punitive action is taken in the form of salary freezes. This approach was most severe during the emergency period. Although the pressure has eased, the emphasis on target achievement remains.

Among our interviewees, eight service providers said that targets in the present form are very much needed. For each service provider, they said, the targets give a clear idea of how much work is to be done within a year. They also give an easy, uniform, and unambiguous standard against which program and performance monitoring can be measured.

Three respondents opposed the use of targets in their present form, saying that they put unnecessary pressure on service providers and detract from optimum achievement. They also said that targets do not give an adequate assessment of program achievement. Rather, what should be monitored is the change in people's attitudes, not the number of operations performed.

There was extensive criticism of the method by which the targets are fixed. A majority held that although the targets for terminal methods and even IUDs are needed, they are unnecessary for reversible methods. The procedure for documenting target achievement of spacing methods is too cumbersome for use in the field, and therefore the reported achievement of such targets is unreliable.

The present method of basing targets on the size of the population, said the respondents, does not make sense; targets should be based instead on the number of eligible couples in the area. In addition, target expectations of family planning workers are unrealistic: instead of being expected to fulfill 100 percent of the target, they should be given a range, with a minimum acceptable goal. Finally, the targets should incorporate other components that are better qualitative indicators, such as median age, parity, number of births in an area within a year, and the percentage of antenatal and postnatal cases attended by field workers.

Information, Education, and Communication. The respondents unanimously agreed that IEC activities have contributed to an increased awareness that both the size and the growth rate of India's population exceed the ideal and that the growth rate needs to be reduced. People now openly discuss overpopulation as a major problem; a few decades ago this was not the case. But the respondents' views on IEC depended mostly on their association with the program. Some respondents criticized the program's IEC activities for being planned and implemented in a dictatorial manner: people were instructed about the population problem and almost ordered to adopt contraception. Respondents also found it problematic that the mass media are emphasized over interpersonal communication for conveying such sensitive information. Finally, respondents observed that, since the output of IEC efforts is difficult to measure, family planning personnel often do not bother to do any work in this area.

An extreme view was that IEC is neither useful nor necessary. The most critical of the respondents said that motivation work is done by the service providers only, and that the program can run without IEC. This respondent added that the most important activity is to empower women, and that IEC is useless for that purpose.

It was suggested that in-depth research is necessary to develop IEC programs that improve people's understanding of the problem directly, in the context of local situations and languages, with a greater reliance on interpersonal communication. The respondents also said that the program should be more participatory, engaging couples and/or women in a discussion about their preferences regarding the timing of childbearing, and that children should be included in IEC activities as soon as they are old enough to understand the issues. Finally, respondents said, the effectiveness of IEC would increase with greater efforts at improving literacy and eradicating poverty.

Quality of Care. Since most of the people interviewed had a long association with the program, they tended to favor a quantitative approach to family planning acceptance. Twelve of the 18 respondents commented on the issue of quality of care; the consensus was that in general the quality of the services provided through the government outlets is quite low. Services are not adequately supported by preliminary research, and follow-up—including treatment for complications—is poor.

In the respondents' view, auxiliary nurse-midwives are partly responsible for the low quality of care, because they do not work efficiently, do not visit the field often enough, and do not conduct check-ups of the clients. The structure of the program also contributes to the problem. Since the numerical indicators of performance receive more attention than qualitative indicators, even doctors overlook such basic precautions as proper sterilization of medical instruments. One of the doctors told about operations that had to be performed in vehicles, and argued that if all service norms were adhered to, no operation would ever be done. The poor infrastructure is also seen in the fact that electricity generators are not available even in the primary health centers, which means there is no back-up in the event of a power failure during an operation. Finally, most of the subcenters do not have delivery tables, and babies are delivered on the floor.

Inadequate care was also blamed on the lack of roads and public transport facilities to contact clients in remote rural areas.

Personnel. The success of the family welfare program depends to a large extent on both the quality and quantity of the personnel. The field-level service providers and the medical officers play a more significant role than other government functionaries or teachers.

Recent medical graduates are frequently posted in primary health centers. They are used to an urban lifestyle and often find it difficult to adjust to the lack of basic amenities such as running water, drainage, transportation, and decent housing when it is not provided by the government. The prospects for promotion are limited. Nonetheless, most of the doctors who are assigned to family welfare work have a lighter load than other doctors, according to the

people we interviewed—partly because they are paid by the central government and nobody bothers to check their work. Many doctors prefer to live or work in an urban location, and they try to get posted at places that have better facilities than the primary health centers. Thus, when a post becomes vacant in a primary health centers, it is very difficult to fill it because most doctors prefer to work elsewhere.

Doctors do not receive any training in administration and accounting—skills that are needed in a primary health center—and they are generally ill equipped to handle such responsibilities. But mistakes in these two areas reflect badly on their careers; as a result, they often become obsessed with administrative and accounting problems, and they neglect high-quality service delivery. Doctors in private practice neglect the program goals and standards to an even greater extent because they are not employed by the government.

Some of the respondents proposed that a medical professional need not head a primary health center. The task can be assigned to a social worker or a public health professional, who is better qualified to attend to the preventive aspects of health care. The problem is that there is an acute paucity of public health professionals in India.

Like physicians, most health workers are recent graduates. Most are also women; not many men want the job because of its low ranking as an occupation. Both male and female health workers are criticized for their lack of commitment and for neglecting their duties. However, they also face difficult problems at the subcenters, which often lack adequate facilities. In addition, they usually have family responsibilities that require them to stay at home and commute to work, rather than staying in the quarters at the subcenter, as they are required to do in an emergency. Transportation to the subcenters is unreliable and slow, so the field workers spend only minimal amounts of time there. They spend much time and effort getting a favorable posting and retain it once they do so.

The field workers tend to be uncomfortable in the villages; as young outsiders, they run a high risk of molestation and sexual abuse by some villagers. They are also responsible for fulfilling targets, and they face rebukes and humiliation from their superiors when targets are not met. On the other hand, once they are confirmed in the job, they cannot be removed from it. The result is a certain complacency, neglect of work, irregular visits or follow-up in the field, and a lower quality of services. Sometimes, clients are advised to come to the subcenter in place of the prescribed home visits.

Nongovernmental Organizations. Only four persons commented about the work nongovernmental organizations could do and their future role. One of these respondents worked in an NGO, so the comments may be biased. Two respondents held that NGOs work in a limited area, which in turn limits their effectiveness. Most of the NGOs do the work, some interviewees said, because they want to get the money from the government or from international agencies. These respondents believe that NGOs get far more publicity than the gov-

ernment departments for even small amounts of work, while the government departments get all the criticism. If the NGOs are allowed to participate more intensely in the program, they said, it will only reduce the effectiveness and the prestige of the government sector. One respondent commented that the NGO contribution is restricted by the requirement to follow the government's program guidelines, which allows them no flexibility in their work.

Transport. Each subcenter and primary health center is supposed to cater to a limited population, but that population is often scattered over a wide area. Clients are not always able to come to the centers, and service providers have to contact people in their homes. The field workers' duties include maintaining contact with the population in the area assigned to them, but they often cannot cover the whole area on foot. The provision of vehicles would increase their mobility and outreach. In a state such as Madhya Pradesh, however, a large number of villages and hamlets do not have any link roads or they have only fair-weather roads, which become nonfunctional during the rainy season (which lasts up to three or four months). The provision of services becomes difficult during this period.

Conclusion

The interviews and related discussions described above underline the limited dialogue between program functionaries and policymakers as well as the rigidities of the Indian administrative system. Often, the respondents considered their opinions to be unquestionable truths and did not want to study the evidence or ascertain the facts. There also appeared to be distrust and suspicion about the motivations of potential collaborators, and few seemed willing to trust or work with different people or agencies.

The problems discussed above are not insuperable, however. Social scientists need to contribute to the family planning program's success by conducting competent research and offering dispassionate analysis of various dimensions of the problems encountered to date.

FOCUS GROUP INTERVIEWS WITH WORKERS AT THE GRASSROOTS LEVEL

The senior functionaries involved in India's development activities are generally unwilling to discuss implementation problems with workers at the grassroots level. This widespread unwillingness to communicate becomes a serious barrier to achieving the goals of social and economic development, and renders policymaking a high-level exercise in which some of the crucial actors do not become active participants. To understand the problems of the field workers and their perspective on the issues of population policy, we conducted two focus group discussions with workers from two primary health centers and from nongovernmental organizations in and around Ahmedabad city in Gujarat. A total of 17 workers in selected rural primary health centers participated in the focus groups during July and August 1994.

To obtain a comparative perspective on the responses of rural workers, a meeting was arranged with 31 field workers and 14 medical officers from 19 family planning centers run by volunteer or nongovernmental organizations in Ahmedabad. Ahmedabad was selected partly on the ground that as the major metropolitan city of Gujarat state, it would probably represent the best conditions in the state. Also, the NGO-run family planning centers were expected to provide the best possible picture. The deficiencies in other centers or clinics were expected to be more serious.

In one primary health center, five female health workers, one lady health supervisor, and three auxiliary nurse-midwives, ranging in age from 26 to 51 years, with work experience from one to 28 years, participated in the discussion. The minimum educational level was eighth standard (the equivalent of eighth grade in the United States) and the highest was the second year of B.A. (equivalent to two years in a four-year college program in the United States). Four participants were Hindus, four were Christians, and one was Muslim. All field work is done on foot. Each auxiliary nurse-midwife/female health worker is responsible for three villages at the most. The lady health supervisor has to cover all seven subcenters that operate under the primary health center.

At the second primary health center, one lady health supervisor, one female health worker, two auxiliary nurse-midwives, and four male multipurpose health workers participated in the focus group. The workers' ages ranged from 28 years to 57 years, and their educational level ranged from eighth standard to secondary school certificate, which is given upon the successful completion of ten years of schooling. Seven were Hindus and one was Christian. Their work experience ranged from nine to 30 years.

Before beginning the focus group discussions, we tried to ascertain from the participants their perception of the three major problems faced by India, in the order of their importance. The participants agreed unanimously that India's large population size was a major problem. A majority (11 out of 17) considered it the most serious problem; the rest gave it the second or third rank. Unemployment, illiteracy, inflation, and poverty were the other common problems mentioned. The important points that came up during the discussions on various aspects of family planning program implementation in the field are discussed below.

Approaches for Establishing Contact with the Community

The program structure makes it easy for health workers to establish contact with the community. The health worker normally makes an initial visit to the field with another primary health center staff member such as the lady health supervisor or the midwife (locally called the *dai*), who is already known in the village. The community leaders such as *Panchayat* members, village revenue officers, and teachers are contacted first. Thereafter, these leaders help in introducing the health worker to the community.

During the initial round of house visits (one or two days), the health worker makes general inquiries about immunizations and the health status of

family members, and advises people to seek help if they need it. Motivation work for the acceptance of contraception usually begins during the third or fourth visit. Thereafter, fortnightly contact is maintained with each family. A continuous watch is kept on the fertility status of women in the eligible couple group. Pregnant women and infants are also watched carefully. Also during these visits, the health worker takes note of migrants and makes suitable entries in the records of immigrants and outmigrants. New immigrants are contacted immediately.

The MPHWs work mostly with men, motivating them to adopt contraception. They also collect blood samples for malaria detection.

Record Maintenance

The family register, which is updated after every field visit, contains information about the fertility status of all female clients, and the health status of pregnant women, mothers, and children younger than five years of age. In addition, separate registers are maintained for family planning, MCH, antenatal care, postnatal care, and so forth. Thus, all client information is recorded in at least three different registers. An average of two hours is spent every day on record maintenance. The requirement of recording the same information in multiple registers is irksome to the field workers, and often their family members have to help them maintain the records.

Factors in Motivating Couples to Accept Family Planning

The family planning workers described a number of factors that appear to have an impact on their success in motivating couples to accept family planning. These factors are described below.

Literacy. It is easier to motivate those who are literate than those who are not. The illiterate population is more skeptical about the benefits of immunization as well as contraception. According to the 1991 Census, 25 percent of rural women and 54 percent of urban women were literate.

Demonstration Effect. The neighborhood example serves as the best motivation: it is easier to motivate people if some couples in the neighborhood, belonging to the same social stratum, have adopted contraception and have a favorable attitude toward it.

Pronatalist Effect of Other Welfare Schemes. Benefits from other welfare schemes increase with an increase in family size, which means that these other welfare schemes appear pronatalist. For example, the larger the family size noted on the ration card, the larger the quota of kerosene, food grains, sugar, and other commodities that a family receives from the government. In other words, the number of persons on a ration card determines the subsidized supply of "essential commodities of daily consumption" a family will receive. Since education (for children up to the seventh grade) and mid-day meals (for children up to age 14) are free, the family's expenditure on children increases only marginally as family size increases. On the other hand, children are the

most assured and cheapest source of labor. There are long waiting lines for every commodity at the public distribution outlets. Large families can spare one member for each line, making it easier to get supplies.

People's Attitudes Toward Health and Mortality. The fact that both women's and children's health deteriorates with many closely spaced pregnancies is of no importance in traditional Indian society. A woman's death is not considered particularly detrimental, as a man can marry again and produce a child at any age, if needed.

The death of a child is generally faced with stoicism, as there is always the hope of conceiving another. Yet, parents appear to be inherently uncertain about their children's survival chances, which leads to a higher actual fertility than desired and encourages childbearing for as long as possible.

Fears About Vasectomy. Vasectomy acceptance has been hampered by the fear of impotence and loss of physical stamina, as well as by men's unwillingness to give up their ability to produce children. If a woman is sterilized, on the other hand, her husband can always remarry if he wants to have another child.

Female Sterilization: Risk of Failure and Other Problems. The female workers reported some problems with female sterilizations as well. First, the failure rate for laparoscopy was reported at around 20 percent. One reason for such a high failure rate could be that the proper pre-operative check for pregnancy is not done. However, as mentioned earlier, because the traditional tubal ligation requires an extended hospital stay, laparoscopy is the preferred method in spite of its high failure rate.

It is also widely believed that tubectomy (tubal ligation) eventually leads to the need for a hysterectomy, usually after a few years—a view that is propagated by private practitioners. Whenever a woman goes to a private practitioner with a gynecological complaint, the doctor asks whether the woman has been sterilized. This creates an impression in many women's minds that sterilization is associated with later gynecological problems.

Difficulties in Promoting the Use of Condoms. Most workers have found it difficult to promote the use of condoms for contraception. As noted earlier, the female field workers interact mostly with women, who have difficulty understanding the proper use of condoms or cannot talk to their husbands about it. In addition, condoms cannot be distributed openly because most rural women do not want to be seen accepting them. These obstacles are magnified by target requirements, which lead field workers to record fictitious entries in the registers and to dump unused supplies at small kiosks or shops or in the wilderness.

Most female field workers favor the IUD. All of them can insert it unaided, and they claim that the retention rate is quite high, although no data are available to support their claim.

Intercommunity Differences in Attitudes Toward Contraception. Members of some communities—for example, Muslims—shun all talk of contraception, largely because of religious objections. Nonetheless, since the family welfare program has been active for a long time, Muslims communities, too are aware that they have full control over their fertility. Many of them have also realized

the benefits of a small family, although they seek contraceptive services covertly because they fear disapproval from other members of their community.

The Role of Family History. The norm for ideal family size is largely determined by family history: a woman's wealth and her status in the family depend upon the number of sons she has, and she is expected to have at least as many sons as her mother-in-law has borne. In order to achieve this ideal, women become pregnant repeatedly.

Before accepting any method of contraception, women generally seek the opinion of their parents, husband, and in-laws, in that order, and they will accept contraception only if these three parties approve. The motivational efforts of the health worker are useless if any one of these three groups opposes the idea.

Administrative Problems Affecting the Health Worker's Performance

Our respondents highlighted several problems that affect their performance and create an adverse impression of their work. Most of these problems seem to reflect the incapacity of the Indian bureaucratic structure to take account of the competition and conflicts in rural areas among the functionaries of different departments.

Differential Capacity of Village Functionaries to Influence People. The family planning program has little to offer people compared with the tangible provisions of other government programs. For example, teachers provide valuable education, and *talatis* (village officials in charge of Land Records) are held in high regard because they collect taxes for the cultivation of land, whereas health workers generally do not even have medicine for common minor ailments. The demand for immunization and contraception is often low and has to be created. The attitude of most clients toward the family planning worker is that they are doing her a favor by accepting her advice because it helps her to retain her job.

Senior Supervisory Officers. Among senior supervisory officers in the family planning program, only the medical officer of the primary health center visits the field. The officers at the district and state levels rarely visit the field and, as a result, have little first-hand knowledge of what is happening there. At district-level meetings, the field workers are treated very badly by senior supervisory officers. They face continuous reprimands from the district health officers for any shortcomings, and they are not allowed to speak about their problems.

A Rigid Approach to Achieving Targets. The program's structure for target achievement is out of step with the realities of rural life. Field workers are expected to fulfill the targets, and no explanation is acceptable for any shortfall. Such rigid expectations ignore the reality that most rural residents are employed in the agricultural sector; the rainy season, which begins in June, is their busy period and they cannot spare any time for undergoing a sterilization procedure. Once the rainy season ends and the crop is harvested around October–November, a festival period follows, along with the wedding season. By January, then, the pressure on field workers to fulfill the targets has become in-

tense—so much so that in one of our focus group discussions, the older workers favored taking an early retirement. At the other site, the younger workers wanted to advise the new entrants against accepting an assignment as an ANM.

Perceived Status Among Village-Level Functionaries. The female health workers compare their job responsibilities with those of other village-level government functionaries such as teachers. Because teachers have more holidays and shorter work hours, the health workers consider themselves to be at a relative disadvantage.

The older group of health workers also expressed the view that the intense pressure of targets has damaged their prestige in the rural community. The younger group, however, said that the villagers give them a great deal of respect because of the help they provide, and they believed that they enjoy an even higher status than teachers. The difference in perceptions about status between the younger and older service providers may not be just a consequence of age, but may be due to the fact that the younger group worked in an area of higher socioeconomic status and a higher literacy rate.

Suggestions for Improving Program Operations

The field workers offered the following suggestions to improve the functioning of the program:

- District- and higher-level officers should visit the field periodically to gain an understanding of the field workers' problems and to help motivate the people to adopt family planning.
- Removing targets may cause some reduction in contraceptive prevalence but it will also remove the heavy pressure of target achievement. Other measures of program achievement, such as the number of births in a subcenter area within a year and the range of services provided by field workers, could be used to evaluate performance.
- Eliminate the payment of incentives. Family planning workers believe that while this may have a negative effect on the program at first, contraceptive acceptance will pick up after a year or two.
- A gynecologist should visit the primary health center on a weekly basis. Such visits will go a long way toward reducing reproductive tract problems; if these problems are treated, contraceptive acceptance will increase.
- The functionaries of all government departments—not just the family planning program—should be involved in motivation work.
- The success of the program depends on a strengthened effort to improve literacy nationwide, particularly in rural areas.
- Field workers spend a considerable part of their training in hospitals, which are much better equipped than the primary health centers and the subcenters. A longer period of training in the field would be more helpful than extended hospital training, at least as a short-term solution.
- IEC activities should be directed at husbands and other influential family members, such as mothers-in-law, not just at women.
- Facilities for the treatment of infertility should be made available.

The Role of Nongovernmental Organizations

In the wake of the Program of Action adopted at the Cairo conference, some effort seems to have been made to increase the dialogue between the government and nongovernmental organizations. The task is certainly difficult, with widespread mutual distrust, misunderstandings, and impatience. However, in view of the paucity of financial resources to expand the public sector, greater reliance on nongovernmental agencies is both essential and unavoidable.

Our discussions with the nongovernmental organizations involved in family planning activities revealed a wide gap between the existing situation and the potential for NGO involvement. The NGOs unanimously voiced their concern that the government did not trust them and did not discriminate between dedicated NGO workers and those who are only interested in the government funds provided to the NGOs for setting up facilities or clinics to promote family planning. The "norms" of assistance (government grants to NGOs) had been fixed almost two decades ago, in the 1960s–70s, and have not been revised to take account of inflation. The delays in the disbursement of funds from the government to the NGOs and the bureaucratic procedures for disbursement have aggravated the problems associated with providing family planning services. As a result, only the NGOs with access to foreign funds can afford to continue to deliver high-quality services.

The NGOs have continued their activities in spite of the government's lack of support because they believe in working to improve the health and welfare of the poor. If the government is serious about encouraging NGO participation in promoting family planning, it must accept them as equal partners and compensate them fairly.

Conclusion

The focus group discussions indicate the possibility of a very useful dialogue between the grassroots family planning workers and the NGOs on the one hand, and the senior supervisory staff and policymakers on the other. Although the focus group discussions covered only one state, the grievances, frustrations, and suggested solutions are more or less the same all over the country, as has been confirmed in several forums. The critical question is whether the government is seriously interested in revising its approach to the family planning program.

PARALLELS BETWEEN POPULATION POLICY AND OTHER AREAS OF SOCIAL ENGINEERING

Various constraints on India's efforts to lower the rate of growth and to restrain the size of population have had a strong parallel in other fields of social engineering. An excellent parallel can be drawn with the program to promote universal literacy and education.

At the time of India's independence in 1947, literacy rates showed marked differences by gender and rural–urban residence. The Founding Fathers aimed

to change this situation by making it a part of the Directive Principles of State Policy, specified in the Constitution, to ensure "free and compulsory primary education for all children up to the age of 14," within 10 years, that is, by 1980. However, actual progress has been much slower and even in 1993–94, the percentage of rural children aged 10–14 attending school was 76 and 56 percent among boys and girls, respectively. The corresponding figures for urban areas were 87 and 82 percent. The rural literacy rates among persons aged 15 and over were 59 and 29 percent among males and females, respectively, while the corresponding figures for urban areas were 84 and 64 percent, respectively (NSSO 1997, pp. A67–72).

As in the case of the birth rate of 25, the target years for attaining universal school attendance have successively been revised to a future year, some five to ten years later. Besides, like the service statistics about the acceptors of reversible methods of contraception, the school attendance data reported by the school administrations have suggested much higher school enrollment and attendance ratios than independent surveys. As in the case of family planning program workers, the training and supervision of school teachers and the infrastructure available to them have been grossly inadequate to achieve the task entrusted to them.

Most states of India have enacted legislation to make primary school attendance compulsory, but it is impossible to implement such laws when the number of persons to be punished for violating the law is quite large. Also, the financial resources provided for the achievement of literacy and educational goals have almost always or in most states been inadequate. The quality of education has also deteriorated in the schools run by the government or the local self-government bodies. The policymakers often announce programs to improve the situation but they remain on paper and do not become a reality.

In brief, the observed shortcomings of the implementation of population policy and the family planning program are shared also by other sectors of social engineering or human resource development.

INDIAN POPULATION POLICY: AN APPRAISAL

In reflecting on the impact of the Indian population policy, one is struck by both its successes and failures. Among the major successes must be mentioned the nearly universal diffusion of the message of family planning and awareness of the feasibility of family limitation through human intervention. Also remarkable is the decline in fertility that has occurred in 12 out of the 17 more populous states of the country, which account for about two-thirds of the country's population, and which have moved more than halfway toward the replacement level of fertility, or a TFR of 2.1. The national TFR has declined from about 6.0 in the early 1950s to 3.5 in 1994; the decline in urban India, with a population of nearly 260 million, has been faster, falling from 6.0 to 2.7 over the same period. Evidence on these welcome changes is based on generally impec-

cable statistics available from the Sample Registration System and a large National Family Health Survey conducted during 1992–93.

Among the failures of the Indian population policy must be listed the fact that compared to its northern neighbor, China, the IMR is higher and life expectancy is lower. The IMR for India in 1993–95 was 74 per 1,000, compared with a rate below 40 in China. Life expectancy at birth in India stood at 59 years during 1989–93, compared with nearly 70 years in China. The contraceptive prevalence rate in India was estimated at about 40 percent during 1992–93, whereas the corresponding estimate for China exceeds 75 percent.

More importantly, the proportion of babies delivered by a trained person or in an institution was no more than 50 percent in 1994. Low-birthweight babies accounted for more than 25 percent of the total, and India's long-pursued goal of integrating family planning with the health care system has yet to be achieved.

Of course, the drop in the birth rate as a result of fertility decline has been largely offset by the drop in the death rate; thus the annual rate of population growth has not declined significantly and remains around 1.9 percent. As noted above, a key achievement of the Indian family planning program has been to help avoid a rise in the growth rate above 2.2 percent, such as occurred in several countries in Africa and Latin America. Even in China, the peak growth rate during the early 1970s was placed at 2.8 percent.

To understand various criticisms of the family planning program, we must clearly state our position with respect to the design and strategy of the program, its implementation, the quality of advice received by policymakers, and in turn the nature of the advice offered by policymakers to program functionaries.

Design of the Program

The design of the Family Planning Program in terms of its emphasis on the promotion of MCH was logical and focused on strengthening the credibility of the health staff among the population. Its emphasis on lowering the level of mortality was also fully justified. Unfortunately, overestimation of the success in raising life expectancy at birth during the 1950s probably produced a false sense of complacency and delayed the introduction of universal immunization in India until the early 1970s.

In another respect, however, the design was deficient because of its inadequate recognition of the difficulties involved in the delivery of services to a population scattered over more than 600,000 villages and nearly a million habitations or hamlet groups, over two-thirds of which had fewer than 1,000 persons in 1991. The primary health centers and subcenters necessarily have to be located in relatively larger villages, and the poor infrastructure of transport and communications limits the outreach of health functionaries.

Monitoring System

The Family Planning Program was to be monitored without a sound data base on the level of fertility and mortality in different parts of the country, such as

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would be available from a system of complete vital registration. In the 1960s, a Sample Registration System was indeed designed to provide state-level estimates of the level of fertility and mortality, but its inadequate funding meant significant delays in the availability of estimates. The alternative of monthly service statistics, a monitoring of the number of acceptors of different methods of contraception, further complicated the effective evaluation of the program. The failure to achieve the centrally prescribed goals was masked by reporting numbers that did not match the realities. In the process, one of the major premises of the program, namely providing a variety of contraceptive methods, was abandoned in favor of maintaining a distorted reporting system.

Overly Optimistic Goals

The overly optimistic targets have also damaged the credibility of the program among functionaries and policymakers. The inherent difficulties of promoting a major program of social engineering without simultaneous progress in the areas of health and education as well as infrastructure, transport, and communications were sadly overlooked. In addition, while in theory the program was not to suffer for want of financial resources, the annual allocations of funds have fallen far short of the requirements. As a result, the program functionaries are given a virtually impossible task, to be achieved with inadequate support in terms of both hardware and software.

The Role of the International Community

Any assessment of India's population policies must take account of the role played by international agencies, particularly the United Nations and the Population Council, in the training of professionals who are competent to analyze population-related issues (Zachariah 1996).

The United Nations contributed to the training of Indian population scientists at the erstwhile Demographic Training and Research Centre in Bombay beginning in 1956. The Population Council made a similar contribution through its fellowships program, which enabled aspiring scholars to pursue studies leading to the doctoral degree and also assisted with midcareer training.

India's limited library budgets restrict the potential for the cross-fertilization of ideas through the exchange of literature. Only United Nations publications, which are supplied free to a few institutions, the journals distributed free of charge by the Population Council, and, to a limited extent, the meetings and conferences organized by the International Union for the Scientific Study of Population continue to provide avenues for the exchange of information and ideas.

The problems are compounded by the fact that the Indian legal system has made it virtually impossible to terminate the services of an employee in the public sector establishments after the initial period of 8 months to a year. The personnel working in a difficult area generally regard their assignments as punishment postings; and as a result, the interregional differences in performance or achievements do not narrow over time.

India's Mistrust of the International Community

India's reluctance to deal with the international community has been compounded by occasional xenophobia within policymaking circles, particularly in the 1970s. Surprisingly, the key decisionmakers were not interested in bringing international experience and expertise into the country, even as they continued to send Indian experts abroad to advise other countries or to work in international organizations. Routine data, such as monthly statistics on acceptors of different family planning methods, were kept confidential, as were the data collected in several baseline surveys conducted in various parts of the country. India was one of the few countries that did not participate in the World Fertility Survey program in the 1970s and 1980s. As a result, India's demographic data were not as solid as they could have been, and the channels of communication between Indian population professionals and the international community became constricted. India's policymakers have sometimes employed radical rhetoric, claiming that the rich diversity of people and cultures within India precludes the need for a dialogue with the international community and provides all the information needed to improve the country's policies and programs.

According to Zachariah (1996), India has "in several cases . . . been slow in recognizing . . . mistakes and taking corrective actions. . . . One basic reason for the slow response and delayed corrections [was] the lack of openness in the central as well as the state governments and their reluctance to [undergo] an independent evaluation of government programs." Less sensitivity to possible criticisms from within India and abroad would have gone a long way toward the development of "more effective policies and programs to deal with rapid population growth." This point is still not adequately appreciated in Indian policymaking circles.

Mobilization of External Funds for the Reproductive and Child Health Program

The government of India has recently attempted to shift its FP program approach away from method-specific targets and to increase its emphasis on reproductive and child health. In order to achieve the goal of ensuring the proper delivery of reproductive health services, the government is seeking about US\$1.2 billion from the international donor community, including the International Development Association (the "soft loan arm" of the World Bank group),³⁴ the European Community, the UNFPA, UNICEF, and other bilateral donors. If the amount is secured and spent over the next Five-Year Plan period (1997–2002), it would be a valuable supplement to the limited national resources available for any innovative program. Assuming an average exchange rate of Rs. 50 per US\$1.00, the external assistance that India seeks is Rs. 60 billion.³⁵ However, given the fact that, by 2001, the total population of India is likely to exceed one billion, the per capita amount will be no more than Rs. 12 per year. Also, relative to the national expenditures for personnel and other needs, external assistance will probably continue to cover a small part—probably no more than one-fourth—of the government's total expenses for the RCH program.

The World Bank has already approved a project for 250 million dollars and a second project of a similar magnitude is in the pipeline. The European Community has also approved another project worth 250 million dollars. The UNFPA has agreed to provide 100 million dollars over a five-year period. Adding to these numbers the contributions by bilateral donors such as the SIDA, NORAD, etc., the total will certainly exceed 1.0 billion dollars.

The Road Ahead

The Indian population policy is presently at a crossroads. As of April 1996, the method-specific targets that had been prescribed by the central government to the country's more than 150,000 female health workers have been abolished. This move was unanticipated. Beginning April 1, 1995, method-specific targets (or targets about the number of users of different methods of contraception to be recruited by each health functionary) were removed from only one or two districts in each major state and their performance under the target-free situation was to be assessed. However, the policy underwent a drastic change without any careful assessment of the experience in the target-free districts. It is difficult to identify the precise reasons. The implementation of method-specific targets for each provider and the monitoring of their performance in terms of achievement of these targets led to an over-emphasis on sterilization and over-reporting and wastage of reversible methods (see Jain 1989; Visaria, Visaria, and Jain 1995). The cumulative evidence of widespread manipulation of the performance indicators relating to the acceptance of reversible methods of contraception even in states considered to be "relatively well-administered" must have bothered the senior policymakers. The Planning Commission was certainly persuaded about the unreliability of service statistics being collected and supplied by the Department of Family Welfare. The targets appeared unnecessary in states such as Kerala and Tamil Nadu, where fertility has declined to near or below replacement level. The possibility of external assistance from the World Bank and other donor agencies to improve the basic infrastructure of health services might have helped the shift in policy, although by early 1996, the foreign exchange reserves of India were large enough to limit the need to alter specific policies for extraneous reasons.

Under the new policy, the targets are to be fixed at the grassroots level, by the health workers in the light of the local performance and felt needs of the people. Such a decentralization was consistent also with the general direction of the governmental policy to strengthen the effective functioning of administrative units below the state levels (called districts). However, the implementation of the policy of decentralized target-setting has proven difficult. In fact, in early 1998, the policy has been renamed as a "community needs assessment approach" rather than the "target-free approach."

As the reported levels of acceptance of family planning have shown a considerable drop after the relaxation of the pressure implied by targets, the so-called target-free population policy has come in for extensive criticism. During a special session of Parliament, called in August 1997 to assess the performance

of India over the previous 50 years, the need to control the size as well as the rate of growth of population was stressed by members of several political parties. Against this background, an influential member of the Parliament argued that "the program is being closed down if you do not set up targets." The advocates of the target-free population policy have been somewhat on the defensive and have argued that they were not against broad overall goals of lowering fertility and the rate of growth of population, but India does not have the capacity to formulate targets about the number of contraceptors or the precise population size at the village, town, or sub-district level.

The recent policy shift has taken place against a background of a significant decline in fertility. It is unlikely that the shifts in the preferences and reproductive behavior of the people over the past few years, evidenced by their changing fertility patterns, are temporary. In addition, the program's new emphasis on reproductive health holds the promise of improving the quality of family planning services and improved services will, in turn, raise the credibility and therefore the effectiveness of rural health workers. The willingness of the World Bank and other donors to provide substantial sums of money for the implementation of a population policy centered on reproductive health is also expected to help change policymakers' approach to population-related issues.

Some policymakers worry that the elimination of targets will lower the motivation of female health workers to promote contraceptive adoption and that the fertility decline will slow down as a result. Some policymakers also believe that the new system does not incorporate any effective way to evaluate worker performance. Therefore, they have prescribed an elaborate system requiring workers at the grassroots level to draw up activity plans consistent with local needs and preferences. However, considerable research is necessary to pre-test, improve, and refine this new system, and to orient it to India's long-term goals of promoting the welfare of its population and attaining a replacement level of fertility as soon as possible.

To improve the formulation and monitoring of the population policy, the data base and the research capacity for sound analysis need to be strengthened. Social scientists with multidisciplinary interests must be trained, and a well-coordinated effort is required to improve the training of public officials likely to participate in social-sector policies. Compulsory registration of all births and deaths, which is to be pursued during the Ninth Plan with the help of the Integrated Child Development Services program, will help to create an important building block for decentralized decisionmaking aimed at India's long-term goals in population, health, development, and family planning.

Notes

1. K. Srinivasan, "Family planning is a dismal failure," *The Sunday Observer* (Bombay), 31 March–6 April 1991. An unsigned article in the *Financial Express* of 26 March 1991 was entitled "Provisional Census fig-

ures: Demographic status quo?" The analyst alleged the "net undercount" in the 1991 Census would have been "at least double of the 1981 rate" because of (a) rapid urbanization during 1981–91 and (b) "the increasing

dissatisfaction" among the roughly 1.6 million enumerators, who are paid a paltry honorarium. The phrase "demographic inertia" was used in a discussion on Indian television around the same time. *The Economic Times* of 2 April 1991 carried a report by the United News of India, which cited Ashish Bose as saying that "the family welfare department should be wound up as it has failed to bring down the population growth rate," and that the 1991 Census figures had revealed that the Department of Family Welfare has failed to deliver the desired results. These allegations and reports reflect some unfortunate errors of judgment rather than the facts of the situation.

2. According to United Nations estimates, the total fertility rate (TFR) in Indonesia ranged between 5.5 and 5.7 during 1950–70, but declined to 3.3 during 1985–90. The TFR in India had declined from 6.0 during 1950–55 to 4.1 during 1985–90. For 1990–95 the UN estimates of the TFR in India and Indonesia were 3.8 and 2.9, respectively (United Nations 1994: 123–128). However, according to data based on the Sample Registration System and confirmed by the National Family Health Survey, the fertility level in India seems to have declined faster than estimated by the UN; the TFR during 1990–92 is placed at 3.7 (Visaria and Visaria 1995). Further, several states of India, with a total population of 231 million, had a TFR of 3.0 or less. Three other states, with a total population of 70 million in 1991, had a TFR of 3.1. According to the World Bank's Development Indicators, the contraceptive prevalence rate during 1988–93 was 43 and 50 percent of couples of reproductive age in India and Indonesia respectively (World Bank 1995: 212–223).

3. The interviews did not follow a fixed schedule or questionnaire; our emphasis was on a dialogue in which the responses could be probed. A Question Bank was prepared as a basic guide for the interviews, and the questions covered some important broad themes. For each theme,

several alternative questions were listed and the one most suitable for the occasion was finally used.

4. Today, the term "prime minister" applies to the head of the central government. The head of a state government is called "chief minister."

5. See Shah (1949): 77–78, 81, 173–174. Rather surprisingly, the subject of abortion was not discussed in India subsequently until the 1960s. On the other hand, eugenic sterilization continued to be pursued repeatedly in the Parliament as a private member's bill introduced by some women members (notably, Ms. Shakuntala Paranjape of Poona). The ambivalent attitude of Mahatma Gandhi on the subject of contraception was reflected in his contradictory statements on the issue. In 1925 he wrote that "there can be no two opinions about the necessity of birth control. But the only method handed down from ages past is self-control." He also argued that with land reform, better agriculture, and industry, India would be capable of supporting twice the population it had in 1925. A decade later, he remarked during a conversation that he believed in "no children." In 1946, he expressed his opposition to the "propagation of the race rabbitwise" but considered the use of "artificial methods [of fertility regulation] . . . a calamity of the first grade." See Gandhi (1947): 37, 44, 200, and 175–176. Gandhi was influenced in part by books about the alleged adverse effects of "artificial" contraception on the population of France and other European countries.

6. Little is known about the deliberations of the Population Policy Committee. Yet, the issue noted in the text is mentioned in Jawaharlal Nehru's letter no. 4354-PM (10 September 1952), addressed to the Minister for Planning, Mr. Gulzari Lal Nanda. The letter has become available through the courtesy of Col. B. L. Raina, who was Director of Family Planning in the Government of India during 1962–63.

7. The Ministry of Health was renamed the Ministry of Health and Family Planning in 1966 and the Ministry of Health and Family Welfare in 1977.

8. The report of the Notestein mission is available in the library of the Office of Population Research at Princeton University. Col. B. L. Raina mentions, in his discussion of the mission's recommendations, items regarding the establishment of a Demographic Training and Research Center, the central family planning board, and the introduction of foam tablets in the program. He does not, however, refer to Notestein's views on the question of clinics. See Raina (1988): 35–37.

9. Letter no. 5-9/66.P&E, dated 25 May 1966, sent by the Department of Family Planning to all state governments and union territories said: "[A]s a part of plan to reorganise and intensify the family planning program, it has been decided to give it a target orientation and to ensure that every possible effort is made to achieve the target. This would also be helpful in assessing results of the program. Keeping in mind the aimed objective of reducing the birth rate from 40 to 25 per thousand by 1975, certain broad norms for the use of different methods of birth control have been worked out. . . ." See Townsend and Khan (1993): 1.

10. After the 1961 Census, the census actuary estimated life expectancy at birth in India during 1951–60 to be 41 years; 41.9 years for males and 40.6 years for females. See Census of India, n.d. The implicit estimate of an increase in the average length of life by 9 years over a decade was a result of the assumption that the National Sample Survey (NSS) estimate of infant mortality during 1957–58 was valid for the country as a whole for the years 1950–59. There is considerable evidence that surveys tend to underestimate the level of infant and child mortality and that the true levels are much higher. The official data continued to show that infant mortality in India during the mid-1950s was 146 per 1,000 (the figure re-

ported by the National Sample Survey for 1957–59). As a result, the progress achieved by India in lowering the infant mortality rate over the past 50 years is grossly understated. According to alternative estimates, the infant mortality rate in India during the late 1940s was around 225—and it had declined to 175 by 1961, and to 133 by 1975. See Jain and Visaria (1988): 28–30, 64. By 1994, the IMR had declined to 74 in the country as a whole.

11. Planning Commission (1966): 346–347. This was the first draft of the Fourth Plan for the five-year period 1966–71. It was followed by a second draft of the Fourth Plan for the period 1969–74.

12. Planning Commission (1969a): 30–31. In reality, according to the Sample Registration System, the birth rate in 1994—that is, two decades beyond the terminal year of the final Fourth Plan—was 29 and the death rate had declined to a little below 10. The rate of natural increase was 1.9 percent. According to the latest population projections, prepared by a Technical Group set up by the Planning Commission in 1996, the population of India is likely to exceed one billion by March 2001.

13. See Myrdal (1968): 66, 895–900. In these "soft states," as the South Asian countries were described, the level of "social discipline" was low, as distinguished from the situation in "the western countries at the beginning of their industrialization." In South Asian countries, "policies decided on are often not enforced, if they are enacted at all, or the authorities, even when framing policies, are reluctant to place obligations on people." Further, "national governments require extraordinarily little of their citizens. There are few obligations to do things in the interest of the community or to avoid actions opposed to that interest. Even those obligations that do exist are enforced inadequately if at all."

14. Sanjay Gandhi became a leader of the Congress Party, while his mother was the Prime Minister as well as the President of the party. He did not, however, hold any official title or position.

15. In June 1967, the Maharashtra cabinet recommended (presumably to the Government of India) "immediate legal and constitutional steps to make vasectomy or tubectomy compulsory in the case of all citizens, irrespective of caste or creed, who have three or more children." In March 1976, the cabinet of Punjab state reportedly approved a Population Control Bill, which provided for fines and imprisonment for couples having more than two children, except when both children were of the same sex or when one of them was handicapped (*The Times of India*, 25 March 1976). Haryana is also believed to have planned similar moves.

16. An illustration relates to the state of Uttar Pradesh, where the government was assigned a target of 400,000 sterilizations by the central government. The state government raised it to 1.5 million. See Pai Panandiker, Bishnoi, and Sharma (1978): 46–47.

17. In a study of 351 individuals in 16 urban and rural centers selected from Bihar, Madhya Pradesh, Uttar Pradesh, and Punjab, Pai Panandiker and his colleagues found that 72 percent of the acceptors had accepted a method of family planning at the bidding of the family planning staff or at the insistence of other government officials. See Pai Panandiker, Bishnoi, and Sharma (1978): 108.

18. In August 1976 it was noted that the "odds are very high that there would be a backlash and the effort to introduce compulsory sterilization would discredit the entire family planning program" (Visaria 1976: 1195).

19. The effective couple protection rate takes account of the number of acceptors of different methods of contraception and weighs them according to the presumed effectiveness of each method in preventing births, with due allowance for aging and mortality of the acceptors of sterilization and the expulsions and removals of intrauterine devices (IUDs). The effectiveness of sterilization and oral pills is assumed to be 100 percent, that of IUDs 95 percent, and

that of other conventional contraceptives 50 percent. The number of couples using condoms is estimated by dividing the number of condoms distributed by 72 (after excluding those given to the acceptors of vasectomy or distributed as free samples). The number of users of oral pills is estimated by dividing the number of oral pill cycles distributed by 13.

20. See Planning Commission (1980): 439–447. The figures refer only to the direct costs, because the personnel and overhead costs are covered under the family welfare (or family planning) budget.

21. The NDC was established in August 1952 to help develop a broad consensus on the development perspective of the Plan. It includes the prime minister and the chief ministers of all states and has met irregularly over the years. Mr. Karunakaran was the Chief Minister of the State of Kerala when the NDC set up the Karunakaran Committee to submit a report on India's population policy. The Planning Commission serves as the secretariat of the NDC, and Professor J. S. Bajaj, a member of the Planning Commission in charge of health, was the member-secretary of the Karunakaran Committee.

22. During 1995–96, the method-specific targets were removed from Kerala and Tamil Nadu, two states in which fertility has already declined sharply. Other states were asked to remove the targets from one or two districts. As of 1 April 1996 the method-specific targets were removed from the entire country.

23. These consultations have been held since June 1996 under the auspices of a network of NGOs, researchers, and activists drawn from the states of Andhra Pradesh, Karnataka, Tamil Nadu, Kerala, Punjab, Haryana, Himachal Pradesh, Uttar Pradesh, and Bihar.

24. The ICDS program was established to provide immunizations and nutri-

tional supplements to pregnant women and their newborns, as well as to young children. The program, operated by the Department of Women and Child Development (Government of India), covers most of the country with a network of honorary workers who ensure the delivery of basic services to women and children in need.

25. Gandhi's "constructive" program was launched to improve the living conditions of India's rural villagers through better sanitation, higher literacy, and so forth.

26. The expression was used by an Indian feminist in discussions at the Tribune during the 1994 International Conference on Population and Development.

27. See Coale and Hoover (1958). The book, supported by the World Bank, considered at length the likely trends in India's population growth and its impact on economic development (with a brief discussion also of Mexico). Early drafts of the book, available in India in 1956–57, were quite influential, although there was skepticism whether the death rate in a poor country such as India could decline as rapidly as it had in Ceylon. In late 1958, after publication of the book by Coale and Hoover, Frank Notestein (Director of the Office of Population Research at Princeton University) met with Prime Minister Nehru, along with Gunnar Myrdal. Notestein presented a copy of the book to the Prime Minister, who is likely to have read parts of it (personal communication).

28. A senior Indian economist recalls that in a leading American university, well known for its liberal orientation, the end of the state of emergency in India in 1977 was welcomed; but the associated end of the serious effort to grapple with India's population problem was met with regret.

29. A country profile for India, published by the Population Council in May 1976, was one of the few publications to make these points. According to some reliable sources,

the relevant passages were underlined and were shown by the senior bureaucrats to the appropriate minister at that time.

30. During 1981–91, Bihar, Madhya Pradesh, Rajasthan, and Uttar Pradesh showed a higher rate of population growth than the national average. With respect to other developmental indicators such as literacy, women's status, and infant mortality, their performance is quite poor. These four large northern Indian states are seen as the likely bastions of continued high fertility in the country.

31. It is widely believed that the extent of coercion was overstated during the elections; however, examples of forcible sterilizations do exist. These forced sterilizations are often considered responsible for unrelated health problems. For one such case, see "Sterilized by force," *India Today* 20, no. 13 (1–15 July 1995): 120–121.

32. According to the survey of four districts of Gujarat state, between 61 and 75 percent of the women expected their sons to support them in their old age. See Visaria, Visaria, and Jain (1995): 184–187.

33. According to the National Family Health Survey of 1992–93, 47 percent of the respondent women had ever used a method of contraception. Of these women, 27 percent had been sterilized, while another 4 percent reported that their husbands had been sterilized (Ramesh, Gulati, and Retherford 1996).

34. The "soft loan arm" refers to the part of the World Bank that lends at a low rate of interest and with a maturity period of 40 years.

35. By June 1998, the Indian rupee has already depreciated to Rs. 42 per US\$1.00. Therefore, the assumed average rate of Rs. 50 per dollar seems reasonable for the period 1998–2001. The rupee may, however, depreciate faster because of the currency crisis in East Asia and the slow growth of Indian exports since 1997.

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AYORINDE AJAYI AND JOHN KEKOVOLÉ

Kenya's Population Policy: From Apathy to Effectiveness

Concern about Kenya's rapid population growth rate dates back to the colonial period. As part of its labor policy, the colonial administration had confined most of the African population to native reserves where pressure on the land had become so severe that the administration grew concerned about the political implications of the increased number of Africans. The administration responded by setting up the Kenya Land Commission in 1933 to assess the future economic needs of the various communities and how land resources could best be utilized to meet those needs (Ndeti and Ndeti 1972). Headed by Morris Carter and later known as the Carter Commission, the 1933 Commission, in the absence of a population census, made estimates of the population size, density, and growth rates of Africans in the various administrative areas. The Commission's report concluded:

All the evidence before us points to a high rate of increase among the native population, and we cannot discern any good reason for expecting any slackening of the rate within the next two decades. It appears more likely that it will increase as a result of the improved conditions of life. It has been suggested to us that later marriages, which may be expected to occur as a result of mission teaching, and possibly as a concomitant of a higher standard of living may cause decline in the rate of increase. . . . For any decrease which there may be in the rate will probably be more than counteracted by an increase in the survival rate both among children and among mothers. (Carter 1933: 349)

The Commission went on to make observations about environmental and land deterioration and the depletion of the country's resources as a result of rapid population growth. The recommendations for relieving the pressure on

the land in the reserves included a redistribution of Africans, and education in better agricultural and pastoral techniques so that the land could be made to support a larger population. The 1930s and 1940s witnessed confrontations between colonial administrators and Africans, particularly the Kikuyu, who had been most adversely affected by the land distribution policy of the colonial administration. By the time the colonial administration was forced to allocate more land to those areas that were considered heavily populated, in the early 1940s, the level of political awareness among the Africans had risen to the point where the Kikuyu had started to organize the Mau Mau rebellion. The feeling that the colonial government had not only robbed them of their land but also subjected them to a form of slavery became a basis for unified political action.

In 1948 the first complete census in East Africa¹ showed that the population of Kenya was 5.4 million. A crude birth rate of 50 per thousand population and a death rate of 25 meant a rate of natural increase of 2.5 percent per annum, which confirmed the impressions of government officials, various commissions, and other observers that the population was growing rapidly. Fourteen years later when the 1962 census was conducted, the population had increased by almost 60 percent to 8.6 million, giving an intercensal growth rate of 3.4 percent which was later revised to 3.0 percent after correcting for gross underenumeration in the 1948 census.

In 1962 John Blacker, who was government demographer and chief interpreter of the census, developed alternative projections of Kenya's population growth relative to economic development. By using per capita income and the savings that would accrue as a result of averted births, he succeeded in convincing some of his colleagues in the Ministry of Planning and Development that unless the newly independent government took specific steps to slow the rate of population growth, the country's efforts at socioeconomic development would be compromised.

There was no reason to expect Blacker's argument to have been taken seriously by the new government or to have had any impact on its policies. But it did have an impact. Tom Mboya was secretary general of the Kenya African National Union (KANU) when Blacker made his projections. As Minister of Planning and Development in the new government, Mboya is credited with being the author of "African Socialism and its Application to Planning in Kenya," the new government's ideological paper that set out the guidelines for development. Often referred to as Sessional Paper No. 10 of 1965, this document contained Blacker's population projections and almost verbatim his rationales for economic growth and arguments for family planning:

The Government's capacity to achieve its desired objectives is restricted by our limited resources, which restrain our ability to expand, by our high rate of population growth, which rapidly increases the size of the task. With population growing in excess of 3 percent per annum nearly seven million jobs will be needed by the year 2000 and over 230,000 adult males will at that time be added to the labor force each year. . . . A high rate of population growth means a large dependent

population, reduces the money available for development, lowers the rate of economic growth and makes exceedingly difficult the task of increasing social services. A programme of family planning education will be given high priority. (ROK 1965: 31)

These concerns laid the groundwork for the first population policy in 1967, and Blacker is widely credited with sensitizing the government to the importance of family planning in its socioeconomic development efforts (e.g., Radel 1973: 48). The concerns have been a recurring theme in national development plans from the first (1966–70) to the current 8th development plan (1997–2001). For instance, the 1966–70 development plan highlighted rapid population growth as one of the most important constraints to economic growth, in addition to the obvious shortages of trained manpower and domestic capital. In the 1974–78 development plan, high unemployment, a diminishing level of domestic savings for investment, pressure on basic social services, and declining real incomes and labor productivity were noted as the major consequences of the high population growth rate.

The 1967 policy did not set any specific demographic targets, and the national family planning program that was initiated from it had no specific goals other than to lower the infant mortality rate while achieving a realistic and acceptable reduction in fertility. A comprehensive revision of the policy was carried out in 1984. This revised policy included demographic, education, and clinical service goals. Sessional Paper No. 1 of 1986, which currently constitutes the cornerstone of the government's economic development strategy, endorsed the challenges documented in the various national development plans and included the balance between rural and urban development as another problem arising from past demographic trends:

For Kenya's development, it is important not only that economic growth should accelerate, but that it should take place as vigorously in rural as in urban areas. The goal of balanced development between rural and urban areas has been an explicit part of Government policy at least since 1970. District focus is becoming an important instrument for achieving it. But the rate of population growth and the threatened explosion of Kenya's major cities requires an intensified concern—and possibly new directions—for this policy. If the urban population continues to grow at the same rate as during the decade between the censuses of 1969 and 1979, it will reach 9 to 10 million by 2000 and account for over 25 percent of the population compared to 15 percent in 1984. This represents a massive shift from rural to urban areas and raises the question of where these new city-dwellers will work and where they will settle. (ROK 1986: 9)

Various socioeconomic indicators during the 1964–94 period, including annual growth in the gross domestic product (GDP), annual growth rates of key sectors (agriculture, manufacturing, government services), wage employment, and the consumer price index (Table 4.1), indicate accelerated economic growth during the 1960s and 1970s and decline since 1980. The annual growth rate of GDP declined from 6.5 percent in 1964/71 to 3.9 percent in 1980, fluctu-

Table 4.1 Trends in Kenya's socioeconomic indicators, 1964–94

Indicator	1964/71	1980	1985	1989	1994
Growth rate of GDP (percent)	6.5	3.9	4.8	5.0	3.0
Growth rates of key sectors (percent)					
Agriculture	4.2	0.9	3.7	4.2	2.8
Manufacturing	8.2	5.2	4.5	5.7	1.9
Government services	9.8	5.6	4.2	5.5	1.5
Gross investment (%)*					
Total	19.7	25.3	23.5	25.6	21.4
Domestic	17.9	18.3	18.3	17.2	10.8
Wage employment (000)					
Total	na	1,191	1,462	1,796	3,355
Modern sector	na	1,006	1,174	1,368	1,504
Informal sector	na	185	288	428	1,851
Consumer price index	<3.0	12.8	10.7	10.7	28.8

* Calculated as a percentage of total investment to total gross national product.

na = not available

Sources: Population Census reports (various), Development Plan 1989–93, and Economic Survey 1995.

ated around 5 percent during 1985–90, and declined to 3 percent in 1994 (ROK 1989; CBS, various years). The 1980s witnessed both the launching of structural adjustment programs aimed at reducing government expenditures, including expenditures on social services such as education and health, and the introduction of cost-sharing programs. Underemployment and unemployment became more evident. The performance of the agriculture sector, the backbone of the economy, deteriorated, and the inflation rate increased. These socioeconomic trends compounded the problems posed by the high population growth rate.

As shown in Table 4.2, in spite of the policies and efforts, the total fertility rate (TFR) increased from 6.8 births per woman in 1962 to 7.9 in 1979 while the population growth rate increased from 3.0 to 3.8 percent during the same period. The results derived from the 1989 and 1993 Demographic and Health Surveys (DHS) indicated an unexpected decline in fertility, with the TFR dropping to 6.7 in 1989 and 5.4 in 1993, the most dramatic drop in fertility ever recorded in Kenya and one of the most dramatic recorded anywhere (NCPD 1994). These data provided some evidence of the start of a fertility transition in the country (Kelley and Nobbe 1990; NCPD 1989; Robinson 1992; World Bank 1992).

STUDY OBJECTIVES AND RATIONALE

The main objective of this study is to assess the evolution, implementation, and effectiveness of the population policy in Kenya. Specifically, the study has the following objectives:

- to describe the evolution and content of the population policy by analyzing its goals and strategies;

Table 4.2 Trends in Kenya's demographic indicators, 1948–97

Indicator	1948 Census	1962 Census	1969 Census	1979 Census	1989 Census	1997 Projections*
Population (millions)	5.4	8.6	10.9	16.1	21.4	29
Population growth rate (% per annum)	2.5	3.0	3.3	3.8	3.4 ^a	3.0
Crude birth rate	50	50	50	52	48	35
Total fertility rate	6.0	6.8	7.6	7.9	6.7	4.8
Crude death rate	25	20	17	14	10	10
Infant mortality rate	184	na	118	104	66	66
Child mortality rate	na	219	190	157	125	108
Life expectancy (yrs.)	35	44	49	54	57	55
Contraceptive prevalence rate	na	na	na	7.0	26.9	39

na = not available.

*Projections include the impact of AIDS.

^aIntercensal growth rate.

Sources: Republic of Kenya, Population Census reports, and Kenya Demographic and Health Survey 1993.

- to document the implementation process, highlighting the major strategies and experiences;
- to ascertain the effectiveness of the policy by comparing the goals, strategies, and implementation process with the results;
- to determine the implications of and the potential solutions to the population problem from various perspectives;
- to compare the evolution and implementation of the population and education policies and their relative performance; and
- to propose a policy framework for future consideration by policy-makers and implementers.

Following the articulation of a formal population policy by the government in 1967 and various refinements in 1984 and 1989, the demographic situation in Kenya has undergone several transformations. During the first, beginning at independence and lasting 17 years, the country witnessed an acceleration in population growth and improvement in basic socioeconomic indicators. By 1980, Kenya was reported to have one of the highest population growth rates in the world, estimated at 3.8–4.0 percent per annum (CBS 1980).

Then, suddenly, fertility rates declined and the population growth rate began to decelerate contrary to earlier predictions by some experts (Frank and McNicoll 1987; Dow and Werner 1983; Sindiga 1985; Henin 1987). The question became: Was this trend a result of an effective population policy? If so, why did it take so long for the policy to become effective and produce results? What evidence is there to support the view that the decline in fertility is sustainable? Finally, what are the broad implications of Kenya's experience for other countries in the region?

SCOPE

This study is based, in part, on a review of available official and public information about the formulation, implementation, and effectiveness of the population policies pursued by the Kenyan government since 1967. The information is supplemented by data collected through interviews held with implementers, professionals, bureaucrats/technocrats, religious leaders, and end-users (married women and men) to solicit their perceptions of the population problem in Kenya. Our analysis hinges on five hypotheses:

1. In spite of the fact that the government foresaw the adverse socioeconomic implications of the high population growth rate, its commitment to tackle the population problem vis-à-vis enhancement of socioeconomic development wavered during the 1967–79 period. The first priority during those years was to demonstrate to the populace that political independence was a springboard for the eradication of socioeconomic “evils” inherited from the colonial regime. Government efforts to deal with the population problem were therefore relegated to the status of an experiment.
2. External forces played critical roles in the formulation, evolution, and implementation of the population policy by sensitizing some of the elite and bureaucrats to the challenges posed by the high population growth rate and, later, by providing funding for policy implementation. However, minimal involvement of policymakers and end-users exacerbated the political sensitivity of the issue and generated resistance to policy implementation at the initial stages.
3. Setting up an appropriate institutional infrastructure was essential for ensuring success. Hence, the maturation period had a vital role to play in the implementation of the policy.
4. Adverse socioeconomic conditions prevalent during the 1980s and 1990s paved the way for the rational consideration of effective measures to curb and eventually reduce the high population growth rate at the macro and micro levels.
5. The apparent success of the population policy was in fact largely attributable to the success of the education policy in increasing primary and secondary school enrollment, particularly for girls, and of health policies.

TYPES OF DATA UTILIZED

Both primary and secondary data have been utilized in this study. Primary data were collected, from November 1993 to January 1994, through interviews with 52 bureaucrats/technocrats who were and still are involved in the development of population policy, 23 religious leaders, 24 implementers mainly from

population NGOs and international agencies, and 466 married women aged 15–49 years along with 303 of their husbands. The collection of secondary data entailed a review of official documents, public statements by policymakers, parliamentary records, mass media coverage, and other publicly available materials.

ORGANIZATION OF THE STUDY

The study is divided into four sections. The first focuses on the evolution and content of the policies that have been articulated since 1965. The second documents and evaluates the implementation strategies by highlighting their major ingredients, successes, failures, and constraints. This section also documents the effectiveness of the policies—mainly the level of achievement of the stated goals and the factors that facilitated or inhibited the success of the policies. The third section describes the solutions to Kenya's population problem as proposed by the people who were interviewed for this study. The final section indicates apparent policy gaps and recommendations for the future.

EVOLUTION AND CONTENT OF KENYA'S POPULATION POLICY

The evolution of any public policy, including a population component, entails certain essential ingredients that guarantee its acceptance by the various groups concerned and assure successful implementation. Hence, we can gain useful insights into the evolution of the population policy in Kenya by ascertaining how the population problem came to the attention of policymakers, and how the policy was developed, implemented, monitored, and evaluated.

First, the issue or problem deserving policy consideration should be explicitly understood by policymakers so that they can have an input in the formulation of the policy. This important input may arise from public opinion and concern or from pertinent information available to policymakers. In the case of population policy, however, Thomas and Grindle (1994) have contended that rarely does it become an agenda item through social mobilization and pressure. They have postulated instead a framework for population policy initiation or change through a policy elite—those officially responsible for making authoritative decisions for government and whose perceptions, concerns, and background characteristics interact with the constraints and opportunities created by the broader context within which they seek to accomplish their goals. The second stage involves the identification of the affected groups or beneficiaries, to help ascertain whether it is individual wellbeing or national wellbeing (or both) that is being considered. The third stage entails the specification of the short- and long-term objectives and targets that policymakers hope to achieve within specified time periods. The fourth and very crucial stage involves the formulation of appropriate strategies or means to be deployed to achieve the stipulated objectives and targets, such as the administrative machinery, requisite resources, procurement of public and political commitment from relevant groups, and so forth. At the fifth stage, monitoring and evaluation systems are

set up to check on the implementation process. Finally, the policy should explicitly indicate the parameters that will be used to measure its effectiveness.

The ingredients that constitute the evolution of a public policy and the Thomas and Grindle framework are utilized here to assess how Kenya's population policy has evolved. We focus on the 1967 policy, the first such policy in sub-Saharan Africa, and on the 1984 policy guidelines, which represent a substantial revision of the original policy. This analysis is supplemented by a look at the evolution of the education policy since 1963.

The 1967 Population Policy

Coming as it did barely four years after political independence, Kenya's formulation of an official population policy in 1967 must have been a surprise to observers within and outside the country. In the giddy post-independence days with the emphasis on nation-building, social welfare, and equitable distribution of income and resources, the notion that a newly independent African nation would need to control its population growth in order to assure its future socioeconomic development was a strange concept. The traditionally strong upward pressures on childbearing that characterized African societies virtually guaranteed that there would be a great deal of resistance before a population policy could be introduced or implemented.

The policy elite was based in the Ministry of Planning and Development. John Blacker, the government demographer, was the acknowledged head of this group before independence. Using the results of the 1962 census, he produced the projections of population and economic growth rates that convinced a number of national leaders that there was a population problem. In particular, two people who were persuaded by Blacker's arguments played key roles in the evolution of Kenya's population policy: Tom Mboya and Mwai Kibaki. Mboya became the Minister for Planning and Development after independence, while Kibaki, an economist, became Mboya's Assistant Minister and, thereafter, the country's Minister for Finance. Other technocrats who were part of this elite at the time included A. T Brough, Chief Statistician, and E. O Edwards, the Chief Economic Adviser to the government. Concern about the impact of Kenya's rapid population growth rate on socioeconomic development has featured in each national development plan since independence.

In April 1965, Mboya's permanent secretary invited the Population Council to send a team of experts to Kenya to:

1. study the population problem in Kenya with a view to making recommendations regarding the ideal rate of growth;
2. recommend a suitable program for effecting the ideal rate of growth;
3. make recommendations on administration of the program;
4. recommend procedures for obtaining funds and technical assistance for carrying out the program. (ROK 1967)

The Population Council team that came to Kenya in response to this re-

quest consisted of four Americans,² who for three weeks in June 1965 visited Nairobi, Mombasa, Kisumu, Nakuru, and Nyeri and had discussions with top government officials and representatives of NGOs and churches. Their report, submitted to the government in August 1965 and released publicly two years later, contained detailed recommendations regarding the four items listed above; these became the basis for Kenya's population policy and program. It is therefore important to examine the key recommendations in that report because of their relevance to the implementation of the policy, in the event explaining why opposition to the policy and program was intense and prolonged.

According to the report,

Mr. Blacker has prepared a projection of Kenya's population to the year 2000 on the assumption of a continued increase in expectation of life in conjunction with a continuation of fertility at its current level. . . . The table [see the box below] shows the increase in number according to this projection, and for comparison, the slower increase that would occur if fertility were reduced by 50 percent in the next 15 years and thereafter maintained at that level. *Note that even this 50 percent reduction in fertility would cause Kenya's population to double in the next 35 years and would result in families averaging more than 3 1/2 children per woman.* This projection roughly indicates the magnitude of the effect of a highly successful but we believe feasible programme of fertility control, which the Government of Kenya might initiate. (ROK 1967: 4; emphasis in the original)

PROJECTED TOTAL POPULATION OF KENYA, 1965-2000, UNDER TWO ASSUMPTIONS OF THE COURSE OF FERTILITY

Year	Population (in thousands)	
	Fertility unchanged	Fertility reduced by 50% in 15 years
1965	9,100	9,100
1970	10,600	10,400
1975	12,400	11,700
1980	14,700	12,900
1985	17,500	14,100
1990	20,800	15,500
1995	25,000	17,100
2000	30,300	19,000

Some analysts commenting on the recommendations of the team have suggested that the main reason the 1967 policy was doomed to failure was because of a conflict of values between the advisers' goal of economic growth and the Kenyans' desire for high fertility (Ndeti and Ndeti 1972). They pointed out that the team could not have been expected to take account of the cultural

values in Kenya after only a three-week visit. We believe that in the immediate post-colonial Africa, a proposal for a 50 percent reduction in fertility was completely out of touch with reality. Worse, by proposing such a drastic reduction in fertility, the advisers raised suspicion that neo-colonial forces were at work, trying to keep the Kenyan population in check as it had done during the colonial days. They unwittingly provided a platform around which forces of opposition would organize. The experience of colonization was simply too fresh.

The advisers, nevertheless, considered such a policy essential and strongly urged the government to declare itself in favor of a reduction in the rate of population growth. They went on to state:

Ideally, one might hope for a public statement by a prominent Government and Party leader, preferably the President, pointing out that for reasons of national and family welfare, a reduction of population growth had become a matter of Government policy. In case such a statement is not advisable politically, the Government should at least send a directive to the employees of the various ministries urging them to cooperate and participate in the family planning programme. (ROK 1967: 14)

It was extremely naive for the advisers to suggest that President Jomo Kenyatta make a public statement in support of population control. Those who knew him attest to the fact that President Kenyatta took his role as symbolic father of the nation and leader of the country too seriously to get involved in a potentially controversial population debate. Not only did he personally view population growth positively but he was also unwilling to lend support to domestic or international groups advocating population control. On at least two occasions, he was said to have threatened to stop the family planning program if his name was associated with it. The Vice President, Odinga Oginga, was similarly an early and persistent opponent of the policy and program because of his belief that black people were being gradually eliminated on an already sparsely populated continent and that the Western races were expanding their wealth and populations at Africa's expense (Ndeti and Ndeti 1972: 41). Still, the government did state its intention to pursue policies to reduce the rate of population growth through voluntary means and established a program under the Ministry of Health to be undertaken in cooperation with the Family Planning Association of Kenya. In late 1966, the Minister of Health, Mr. J. D. Otiende, sent a memorandum to his staff announcing the national family planning program, but he delayed the public announcement of the program until the 20th Assembly of the World Health Organization in Geneva in May 1967. At a press conference in Nairobi on his return from Geneva, he explained the decision to launch the program as follows:

This decision is not influenced by any desire to limit the population increase, but mainly by the realization that changing conditions in our country have resulted in a very reduced spacing of children. This we consider leads to a lowering of maternal and child health and many large families find it increasingly difficult to provide the necessities of life. (*East African Standard*, 16 May 1967)

We mention one other recommendation contained in the advisers' report because of its implication for the design and orientation of the national family planning program. The advisers had stated:

We believe that the family planning program in Kenya should rely heavily on the intra-uterine device. Its cost is exceedingly low, a single insertion can suffice for years and it requires only a single motivation on the part of the recipient. . . . Accordingly a realistic target for a national population program would be a planned build-up within five years of a structure that would introduce birth control at a rate that would cut fertility approximately in half within 10 or 15 years. . . . To achieve the above result would require the organization of a programme that at the end of five years could introduce 150,000 intra-uterine devices each year, and provide supplies of other methods of contraception to an additional 50,000 couples. (ROK 1967: 15, 10)

Thus, not only was the proposed program to be implemented by the Ministry of Health, but the method of choice was a clinic-based, provider-dependent method under the control of physicians, many of whom were opposed to the use of family planning for population control. Even assuming that the demand for contraceptive services was already present, the limitation of facilities and providers ensured that it would take decades before the demand could be met with this approach. By that time, the target would have shifted.

We have gone into this level of detail because it is generally agreed that the recommendations of this advisory mission provided the basis for the formulation of Kenya's population policy and family planning program. We found no evidence of any significant level of discussion or debate on the recommendations before the policy was adopted and the national family planning program was formulated. This is hardly surprising given the sensitive nature of the subject. As the Director of Medical Services was later to put it:

We decided, therefore, that the Ministry of Health and the Family Planning Association should get together and launch a programme, do it quietly, say as little as possible about it and carry on with delivering the goods which is what we are now trying to do. (Likimani 1970: 2)

So effective was the early opposition to population control that the policy became a series of progressively watered-down statements by government officials affirming the government's concern at the rate of population growth and committing itself to a program of free, voluntary family planning education and services in all government hospitals and health centers throughout the country. The program was established in 1967 under maternal and child health services, with an emphasis on child spacing rather than limitation of births. Assistance was also provided to those with infertility problems. Until the 1974–78 Development Plan, the program had no targets and no means of evaluating its accomplishments. That plan was the first to include specific targets for numbers of family planning acceptors. Successive national development plans have built on this, expanding clinic-based and outreach services to achieve family

planning targets. Program administration and research and evaluation activities were also to be strengthened. However, in each of the development plans, the government committed itself to providing no more than 25 percent of the budget required to fund the program; the remainder was expected from foreign donors. This government commitment was not fulfilled, as reflected in the subsequent minimal budgetary allocations to the program.

But apart from the efforts of the opponents of family planning, the government's own commitment to reducing population growth was minimal during the immediate post-independence period. Throughout the 1960s the economy grew at least twice as fast as the population. Political leaders and educated Kenyans did not believe there was a population problem and, if it existed at all, socioeconomic development was the solution. The struggle for political independence that Kenyans had just experienced encouraged their belief that they were in control of their socioeconomic development. The immediate post-independence period to the early 1970s witnessed rapid expansion in both the agricultural sector, which grew at an average rate of 6.2 percent per annum, and the smaller industrial sector, which grew at an average of 12.4 percent. In 1967, the year the family planning program was launched, the overall economy grew by 9.5 percent. All this occurred at a time when the rate of population growth averaged 3.4 percent per annum. Although Kenyans living in rural and urban areas did not benefit equally from this rapid economic growth, there was no question that the average standard of living was much increased during this period. But more significantly, the performance of the economy gave policymakers in Nairobi a new sense of optimism about the future and undermined their commitment to reduce the rate of population growth. Although unemployment was seen as the only dark cloud on the horizon, the government's response was to increase the rate of indigenization of the economy and reduce reliance on foreign skilled manpower. The country needed to experience the difficult economic period of the mid to late 1970s in order to fully understand the difficulty of meeting the socioeconomic aspirations of its people while the population was growing rapidly.

The 1984 Policy Guidelines

By the time President Kenyatta was succeeded by President Moi in 1979, Kenya's population growth rate had reached an all-time high of 3.8 percent per annum and the total fertility rate of 7.9 was the highest ever. The economy had started to experience difficulties, the oil price increases of the mid-1970s had taken their toll, coffee and tea prices had declined in the world market, and a severe drought in 1979 badly affected maize production and led to severe food shortages especially in the urban areas (NRC 1993: 70). The country had a large current account deficit amounting to over 15 percent of the GDP by 1980 (CBS 1983). In 1980, a structural adjustment program had to be implemented, with the devaluation of the currency, cuts in public spending, and other measures to reduce the deficit. The economy became increasingly dependent on foreign

assistance. Parents were forced to shoulder more of the burden of educating their children and for healthcare.

In its fourth national development plan, 1979–83, the new government introduced another dimension to its efforts to reduce population growth, by committing itself to creating attitudes that favor a reduction in the average size of Kenya's families. The 1979–83 Development Plan further strengthened service delivery activities and sought to intensify information and education activities to make parents aware of the benefits of a smaller family size. Service delivery facilities were to be expanded in the rural areas and the number of personnel trained to provide services would be increased. A new cadre of rural family health field educators was to be recruited and trained.

With President Moi as head of state and Mwai Kibaki as his Vice President, the stage was set for effectively dealing with the population problem. President Moi seemed to understand instinctively the need for creating a demand for a smaller family size. His background as a teacher had led him to emphasize education, and as Vice President during the 1960s he encouraged Kenyans of all tribes to send their children to school, especially girls. When he announced his first cabinet in November 1979, he split the functions of the Ministry of Education, which at the time was consuming 40 percent of the country's recurrent budget, into basic and higher education so that it could better concentrate on the job of educating Kenyans. By the end of 1979, a new marriage bill had passed through parliament that provided equality for women in matters pertaining to marriage rights, especially with regard to inheritance and property. The new law also allowed wives to acquire property independently of their husbands. The change in political leadership and atmosphere is perhaps best captured by the following commentary:

Until recently, calls for family planning have come from economic technocrats and among politicians, from the Minister of Finance Mr. Mwai Kibaki (now Vice President) and the late Tom Mboya who was responsible for much of the country's economic philosophy. The late President Kenyatta never fully and publicly committed himself to family planning, and throughout his administration, demographers looked in vain for a strong statement at a national day supporting family planning. So lacking was political direction in the family planning program that family planners spent most of their propaganda effort trying to convince the public that family planning did not mean that a couple could not have all the children they wanted; it merely meant spacing children out so that the mother's health was not ruined by too frequent childbirth.

Now the euphemisms are gone. The economic vicissitudes through which Kenya is passing and the fact that the country is growing at a phenomenal rate of 4 percent per annum, the highest in the world, has forced the government to adopt a blunter terminology and tactics in its family planning campaign. President Daniel arap Moi has given the lead in pleading to Kenyans to have only the number of children they can afford to feed and care for. Seminars have been held for members of parliament and government officials to drum home the message of family

planning and now individual politicians are speaking out. The most recent example of outspokenness on the subject came from the Minister for Constitutional and Home Affairs, Mr. Charles Njonjo, who told fellow politicians in the national assembly last week that Kenyans must stop breeding like rabbits. Njonjo's sentiments went further than mere alarm about the population increase; he suggested some practical steps to be taken to help curb the population increase. Njonjo wants to make it difficult for couples to indulge in large families willy nilly. He wants the government to provide free education only to the first child leaving the rest of the children to be educated at the expense of their parents. According to Njonjo, Kenyans could do well to learn from birds who do not lay eggs until they have built nests.

In the past such talk would have resulted in boos and cat calls from back benchers accusing Njonjo of suggesting foreign solutions to African problems. This time, virtually every MP who spoke supported the need for family planning. (*Weekly Review*, 24 October 1980: 13)

By this time, the policy elite had expanded to include technocrats and academicians outside the Ministry of Planning. Professors Simeon Ominde and R. A. Henin, the latter an adviser from the Population Council based at the newly created Population Studies and Research Institute, played crucial roles in the "Kenyanization" of the expert advice. The government's renewed efforts to deal with population growth led to the establishment of a National Council for Population and Development (NCPD) in 1982 with the mandate to formulate population policies and strategies and coordinate activities aimed at reducing Kenya's population growth rate. At its launch, the Vice President and Minister for Home Affairs, Mr. Mwai Kibaki, under whose ministry the NCPD was established, emphasized that the government was going to be more aggressive in promoting family planning. One of the early activities of the NCPD was the development of new population policy guidelines and the preparations for Kenya's participation at the International Conference on Population in Mexico City.

A meeting of national leaders convened in July 1984 was attended by over 2,000 ministers, assistant ministers, members of parliament, senior government officials from national, provincial, and district levels, social workers, health officials, representatives of NGOs, and officials of several donor agencies. World Bank President A. W. Clausen gave the keynote address at the two-day seminar, which was chaired by the Vice President. The meeting had three principal objectives: to examine general population trends and their implications for Kenya's social and economic development and to explore possible solutions; to provide a forum for Kenyan leaders at all levels to share information on population and development; and to discuss Kenya's draft population policy guidelines and develop national strategies and a plan of action. The participants resolved that the time had come for Kenyans to make concerted efforts to reduce the population growth rate; that all government ministries and agencies and all NGOs must specify population components in their development programs and must pursue them effectively; and that each District Devel-

opment Committee should develop strategies to help achieve the national target of reducing the population growth rate from the current 3.8 percent per annum to 3.3 percent per annum by the end of 1988. The seminar participants also outlined specific recommendations about the role of leaders, of education, and of clinical services in the attainment of this target. This marked the first time the government solicited broad-based support for its efforts to reduce population growth. The resulting policy paper was discussed in the cabinet and approved in parliament as Sessional Paper No. 4 of 1984.

None of this is meant to suggest an absence of political opposition to a government family planning and population program. Nevertheless, the strength of the government's commitment to dealing with the population issue is best illustrated by an incident in 1984. In early November, a few months after the leaders' conference, the Lions clubs of Nakuru and the Giants group of Nairobi started family planning camps in Kiambu, Nakuru, and Kisumu with the aim of performing surgical sterilizations on women who requested the service. Supported by the Ministry of Health, the camps were set up to supplement the government's efforts in family planning and to reduce the waiting time for the procedure, which in some cases was more than six months. A week later, Catholic bishops issued a statement opposing the camps, describing sterilization as a mutilation of the reproductive organs for the direct purpose of preventing conception and saying that this was against natural law. The following week, the Catholic Lay Council issued a statement condemning the use of contraceptives by youth and endorsing the bishops' stand on the sterilization camps. But criticism of the Catholic bishops was quick and direct:

The decision by Roman Catholic Bishops of Kenya to protest some aspects of Kenya's family planning programs continued to be criticized by different quarters this week. The bishops had attacked the female sterilization clinics that were being conducted in various parts of the country by the Lions club, aimed at supplementing the government family planning programs. The bishops' protests were not directed at the idea of FP [family planning] but at the use of artificial methods and they are particularly enraged by the clinics which they said were a destruction of fertility and an insult to Kenyans.

The most significant responses came from V-P and Minister for Home Affairs, Mr. Mwai Kibaki, when he was opening the Union of Radio and Television Networks of Africa (URTNA) family health broadcast workshop in Nairobi. Though he did not mention the protests by the bishops, it is unlikely that Kibaki had anyone else in mind when he called on those opposed to FP to address themselves to the alarming factual information compiled by the World Bank on the population problem in Kenya. Kibaki's message was that the dire economic implications of Kenya's high birth rate were too serious to be ignored and, in what was seen as a swipe at the Kenyan bishops, he cited the example of Mexico where the population growth rate had been reduced from 3.1% per annum to 2% despite its being a predominantly Catholic nation. The URTNA workshop is aimed at increasing the amount of information available on FP and Kibaki gave a number of statisti-

cal examples that underline the urgency of the population problem. Part of the program to curb the birth rate, he said, is to make contraceptives available to all those who need them by increasing service delivery points from the 400 existing now to 800 by 1986. This will also include the use of community-based delivery methods of distributing contraceptives.

Remarks such as these are a sign that the government has no intention of reviewing its recommended methods for family planning despite protests from the Catholic Church. This position was confirmed by the executive director of the NCPD, Mr. Leonard Ngugi, in an interview with the *Weekly Review* this week. Ngugi said that the government does not accept the view of the bishops on these matters and it will continue to encourage the use of all family planning methods. The Catholic Bishops, he said, are entitled to their views but the government responsibility is to inform and educate the public on family planning, after which individuals are free to choose whichever method they deem fit. (*Weekly Review*, 23 November 1984: 12–13)

Such a lively debate on population policy and family planning was totally absent during the Kenyatta regime, and the firm stand and endorsement of the program given by President Moi would have been unthinkable during that period.

We have seen how the policy elite introduced the population issue onto the government agenda. In the 1963–67 period, the policy elite was mainly expatriate, based in the Ministry of Planning and Development. Their activities were direct and visible. In the 1979–84 period, the policy elite was mostly indigenous, with a base in the office of the Vice President. Although external influences were still present during this period, their impact in defining the content of the policy agenda was less direct. This allowed a much more indigenous definition of the population problem and provided opportunities for creative and locally appropriate solutions to be developed. As we discuss below, external forces continued to play a vital role in providing new program ideas, technical assistance, and funding for the implementation of the program once it got underway. The World Bank provided funding for setting up the structures, including the establishment of the NCPD and upgrading the physical facilities of the health care system. The United States Agency for International Development was particularly active in providing funding and technical assistance for service delivery, including experimental non-clinic-based service delivery approaches and for the periodic surveys that provided the benchmarks for performance. The United Nations Fund for Population Activities provided funding for service delivery, training, and deployment of NCPD and other staff.

The Formulation of Population and Education Policies: A Brief Comparison

The education sector has recorded impressive progress since 1963. The total primary school enrollment increased from 890,000 in 1963 to 5,557,000 by 1994. Enrollment rates in primary schools have remained above 90 percent since the

mid-1970s. Secondary school enrollment increased from 30,000 to 620,000 during the same period (CBS, various years). University enrollment also increased from 571 in 1963 to 39,340 by 1994. Thus, the education sector provides a model of the key ingredients for designing and implementing effective public policy. This comparative analysis aims at highlighting the major deficiencies in the formulation of the population policy.

The formulation of education policy had impetus from the government's commitment to provide high-quality education to meet the country's work-force requirements and to improve the general literacy level of the population as a basic need, as highlighted in Table 4.3. It was not easy to articulate a comparable goal for population policy. One of the important results of the early

Table 4.3 Major components in the evolution of Kenya's population and education policies

Component	Population Policy	Education Policy
Statement of problem	High population growth rate and high fertility	Illiteracy due to lack of educational facilities
Rationale	Reduce negative effects of rapid population growth on future socioeconomic development	Improve literacy and educational levels of the population for national and individual welfare
Target groups	Mainly married women of reproductive age	Adults and school-age population
Goals/Targets	Reduction of population growth rate with special emphasis on reduction of fertility	Eradication of illiteracy and increase in enrollment at all levels of education
Strategies to achieve stipulated goals/targets	<i>Institutional set-up:</i> Ministry of Health mandated to take responsibility (1967–82) National Council for Population and Development mandated to coordinate the population program and act as the policy formulation arm of the government after 1982 <i>Resource availability:</i> Not clearly stated <i>Political commitment:</i> Not perceived as an important factor Taken for granted	<i>Institutional set-up:</i> Ministry of Education given full responsibility <i>Resource availability:</i> Budgetary allocations perceived as a requirement and provided <i>Political commitment:</i> Perceived as a critical input Public participation taken seriously as a critical factor
Review of the policy	1984 1989 (partial)	1964/65 Commission Report 1972 Study Report 1978 Committee Report 1981 Presidential Working Party Report 1988 Presidential Working Party Report
Monitoring and evaluation	Not considered in 1967 Taken seriously in 1984 and 1989	Taken seriously

and sustained emphasis on education was that it became a highly valued good. Indeed, when the costs borne by parents increased dramatically in the early 1980s, parents were willing to make tremendous sacrifices to educate their children, and they made the rational decision to reduce their family size goals to provide fully for their children (Kelley and Nobbe 1990). As Dow and colleagues point out, it was not the rapidly rising cost of education (or health or other amenities) that was the key to a reduction in desired family size in Kenya in the early 1980s, but rather “parents’ prior acceptance of an obligation to provide such access at virtually any cost” (Dow, Kekovole, and Archer 1997: 57).

Unlike the evolution of the population policy, which faced prolonged time lags in the review process (1967–84), five review commissions were set up to develop and implement the education policy (ROK 1964, 1972, 1978, 1981, 1988). These commissions (which also took the form of committees and working parties) sought to address prevailing national demands and aspirations. In most cases, issues related to availability, quality, and appropriateness of the education system were addressed. The evolution of the population policy, on the other hand, was characterized by a lack of focus and hesitant commitment from the government and the public at large until the early 1980s, when the government realized the adverse consequences of the high population growth rate.

The government allocated substantial resources to the education sector, but not to the population sector, continuing to spend almost 30 percent of its budgetary allocation on education (CBS 1991 and various years). In fact, recurrent expenditure on education increased from 2.3 percent of GDP in 1969/70 to 5.3 percent in 1974/75 and to 6.4 percent in 1990/91 (CBS 1995 and various years). Parents and communities were obligated to pay for development expenditure (physical facilities, school uniforms, books, and so forth) as agreed upon by parents’ and teachers’ associations. The family planning program, on the other hand, received minimal funds, most of which came from donor agencies and NGOs. This trend has persisted to date.

As observed above, the 1967 population policy was limited in scope. It was also externally driven. For one thing, it ignored people’s desire to improve their standard of living, which had been suppressed by the colonial regime. Hence, the increase in population was of minimal consequence to them. Furthermore, the policy did not articulate the strategies that would be utilized to make resources available to the population sector, particularly the family planning program; nor did it stipulate the requisite monitoring and evaluation procedures to assess its performance.

The 1984 population policy, on the other hand, took advantage of the prevailing socioeconomic and demographic conditions to impress upon policy-makers and the public the adverse effects of a high population growth rate. The establishment of the NCPD as a coordinating body placed the population issue high on the government’s agenda and ensured that there was an infrastructure for coordinating intersectoral activities for implementing the policy. This policy recognized the role of socioeconomic development, particularly fe-

male education and employment, and sought the participation of more agencies and ministries in tackling the population issue, as opposed to leaving the problem to the Ministry of Health. The policy was also more specific with regard to target-setting and more comprehensive in its consideration of migration and mortality.

IMPLEMENTATION AND EFFECTIVENESS OF THE POPULATION POLICY

The effective implementation of any public policy hinges on several critical factors. These include institutional capacity; availability of resources; participation of various constituents such as policymakers, beneficiaries, and bureaucrats; and monitoring and evaluation of the related programs. Our review of implementation strategies focuses on institutional capacity-building, resource availability, political will and commitment, service delivery strategies, and strategies to monitor and evaluate the programs. This material is supplemented by the views of various constituents regarding policy implementation.

The evaluation of the effectiveness of any policy is highly dependent on the identification of appropriate indicators for measuring perceived or stated policy goals. The level of effectiveness, however, is conditioned by the efficacy of the implementation strategy at both the national and individual levels. National-level achievements can be perceived as reflecting the common good, while individual-level achievements can be assumed to measure individual wellbeing.

The following review of implementation strategies and policy effectiveness distinguishes three time periods: 1967 to 1979, a period of dramatic increase in fertility and reduction in infant and child mortality; 1980 to 1989, a period that witnessed signs of declines in fertility; and 1990 to 1993, a period that registered further declines in fertility.

The 1967–79 Period

Implementation. Having accepted the advice of the team of consultants and committed itself to a policy of reducing population growth, the government established a program of family planning information and services in 1967 to be implemented under the Ministry of Health. As we have shown, a low level of political commitment coupled with widespread opposition led to the formulation of a program that was unfocused and weak. Although family planning services had been provided for over a decade by the Family Planning Association of Kenya, 1967 marked the beginning of a government program. The program was wholly voluntary, clinic based, closely coupled with maternal and child health services, and emphasized child spacing rather than limitation of family size. In addition to provision of contraceptive services, the program provided assistance to couples with infertility problems.

Institutional Capacity-Building. From the beginning, the government recognized the need for an administrative system that would ensure the effective

implementation of the population policy. In late 1967, a National Family Planning Council was set up consisting of representatives of various ministries and the Family Planning Association of Kenya with the mandate to supervise, coordinate, and administer the program and establish service delivery policies. The Council had to be dissolved after its first meeting because of internal disagreements, although the Working Committee of the Council survived under the chairmanship of the director of medical services (Ndeti and Ndeti 1972: 36). After the dissolution of the Council, administration and coordination of the program came under the full jurisdiction of the Ministry of Health, with responsibility for information, education, and motivation assigned to the FPAK. It was clear that the government did not want to risk direct criticism by taking the responsibility for informing the public on a sensitive and controversial subject.

The Population Council advisers had recommended a program based on an effective, long-term, clinic- and provider-dependent method. However, since the government focused mainly on maternal and child health services, the lack of clinics with trained family planning providers virtually ensured that the majority of clients seeking contraceptive services had to use the pill. In those early days, pill acceptors with low motivation to use contraception often discontinued use within a few months. In the convenient division of labor between the Ministry of Health and the Family Planning Association of Kenya, FPAK fieldworkers were assigned to home visits, motivation, and referral of clients for clinical services. Many of the full-time fieldworkers worked only a couple of hours a week and they did not have adequate skills to counsel first-time acceptors to continue contracepting. Dropout rates were very high.

Resource Availability. The Kenyan government's commitment to providing adequate health services, including an MCH/FP program, was demonstrated by the allocation of substantial resources to this sector. However, the share of family planning activities in the overall Ministry of Health budget remained insignificant. The bulk of the expenditure on family planning activities was borne by NGOs and external donor agencies: the United Nations Fund for Population Activities, World Bank, British Overseas Development Agency, United States Agency for International Development, and others.

This period witnessed substantial progress in the construction of health facilities and recruitment of personnel for maternal and child health services (Sinding 1991; World Bank 1992). The number of hospitals increased by 67 percent, the number of health centers increased by 40 percent, and the number of dispensaries almost tripled. The rapid expansion in the number of dispensaries was primarily a result of the government's policy to enhance primary health, especially rural health and maternal and child health. As a result of these efforts, infant and child mortality declined substantially while the total fertility rate increased to the highest level ever recorded for any country.

Political Will and Commitment. The effective implementation of a population policy requires strong political support to encourage a positive public opinion and to assure that the requisite financial and human resources will be

available. Political apathy can undermine efforts made by implementing agencies. In our conceptualization, political will has been perceived as public utterances by senior policymakers and political statements in the form of manifestos that positively support the population agenda—in this case, the promotion of family planning activities, with the primary objective of reducing the high population growth rate.

As noted earlier, the 1967–79 period was characterized by minimal political support for the population policy. President Kenyatta's personal views on the subject discouraged other leaders from sensitizing the public on the adverse effects of high population growth rates on their livelihood. A review of parliamentary debates and speeches made by various politicians indicates that the population issue was accorded the lowest priority on the political agenda. The majority of political leaders felt that rapid socioeconomic development was the ultimate solution to the population problem.

Service Delivery Strategies. Between 1967 and 1979, the service delivery system remained predominantly clinic-based under the Ministry of Health, with the Nairobi City Commission and the FPAK running a small number of clinics, including mobile units sponsored by the IPPF to serve outlying populations. The number of government clinics offering family planning services increased from 56 in 1967 to 275 in 1974, roughly one-third of the country's total health facilities. Largely because of a shortage of trained personnel and the overriding demands for curative services, relatively few family planning services were being provided by the government clinics, many of which provided services only weekly, or even monthly. In 1974, for instance, FPAK's seven mobile units serving 90 clinics throughout the country accounted for one-third of all new acceptors and the Nairobi City Commission's 43 clinics accounted for 15–20 percent of the acceptors (Krystall et al. 1975: 286–290). As shown in Table 4.4, the pill accounted for almost 80 percent of the contraceptive services offered in 1974 while the IUD, with 5,000 acceptors, accounted for about 10 percent. This contrasts markedly with the suggestions of the Population Council advisers, who had recommended a predominantly IUD-based program providing 25,000 devices in the first year and building up to 150,000 devices at the end of the fifth year.

The existence of a population policy and a government-sponsored family planning program so soon after independence made it possible for foreign-funded organizations and institutions to be openly involved in family planning activities in Kenya. The demise of the National Family Planning Council in 1967 meant that there was no policy coordinating mechanism and essentially left each organization to develop its own strategies and implement its projects and activities. From the early 1970s several organizations, most of them US-based, established a presence in Kenya and proceeded to implement family planning projects to supplement the government's efforts. The results of their efforts were often mixed. In one case it was disastrous.

Tim Black arrived in Kenya in 1971 representing Population Services International (PSI) and developed a project to test the potential for social marketing

Table 4.4 Number of clinics providing family planning services and number of clinic visits and acceptors by method, Kenya, 1967–74

Year	No. of clinics	Clinic visits (in thousands)			Acceptors (in thousands)			
		First visits	Revisits	All visits	Pill	IUD	Other	All methods
1967	56	u	u	u	u	11	u	u
1968	116	12	18	30	5	4	0.2	9
1969	202	30	73	103	9	15	2	26
1970	253	35	114	149	10	18	3	31
1971	246	41	139	180	27	10	4	41
1972	223	45	172	217	34	5	4	43
1973	298	50	211	261	37	5	5	47
1974	275 ^a	51	233	283	39	5	5 ^a	49

u = data are unavailable.
^a 3,000 of these clients, or some 60 percent, accepted injectables.
Source: MOH from ROK Statistical Abstracts 1975, pp. 205–267.

of contraceptives as a complementary distribution system to the public health services. He chose to implement the project in Meru district and collaborated with FPAK. When the Kinga³ Project was launched in 1972, it sponsored balloon and condom blowing competitions in an effort to familiarize people with the condom. The marketing was aggressive. The project, however, ran into trouble when parents discovered their children buying condoms and inflating them. The Ministry of Health was notified and Tim Black had to leave the country before the end of the year. It would take more than two decades before another social marketing project could be developed and implemented in Kenya.

In contrast to this, the Program for Better Family Living, also established in 1972, was directed by Eric Krystall and funded by the United Nations Food and Agriculture Organization. The objective was to integrate population education in agriculture, food, nutrition, home economics, and other rural development programs by training community workers and providing information to local policymakers and administrators so that these opinion leaders would communicate this understanding to the people with whom they worked. Most observers believed that the project was well conceived and implemented and that the integrated nature of the program ensured that it was effective and acceptable to the people. When FAO funding ended four years later, most observers expected the program would be absorbed by the Ministry of Agriculture or the Ministry of Social Services. Because of in-fighting among the many ministries, however, it ended up in the Ministry of Finance and Economic Planning, which had no program implementation responsibilities whatsoever.

Monitoring and Evaluation. As indicated earlier, the 1967 policy did not address the issue of monitoring and evaluation. However, after the national family planning program was initiated, the statistics section of the MOH introduced clinic record cards, which were to be used by all family planning clinics. The cards collected basic information at the first visit such as name, age, mari-

tal status, education, number of pregnancies, previous contraceptive practice, and medical history and examination. They also provided information on dates of revisits. Because there was no information on continuation rates for pill users or retention rates for IUD acceptors, the overall effectiveness of the national program could not be evaluated. By 1974, however, less than 2 percent of women of reproductive age were using a modern method of contraception. In addition to the efforts of the statistics unit, information was also derived from population censuses and demographic surveys, although long time lags were experienced in getting the necessary information to policymakers and implementers.

Effectiveness of the Policy. The years from 1967 to 1979 witnessed an increase in the total fertility rate and in the rate of population growth, as documented in Table 4.5. These developments were contrary to the 1967 population policy prescription, which aimed at reducing fertility and, hence, the popula-

Table 4.5 Stated goals and achievements of Kenya's population policy

Goals	Achievements	
	1969	1979
1967		
1. Reduction of population growth rate from 3.3 percent to 3.0 percent in 1979	3.3	3.8
2. Reduction of total fertility rate	7.6	8.0
3. Reduction of under-five (child) mortality	192	157
4. Reduction of maternal mortality	na	na
1984	1989	1993
1. Reduction of population growth rate from 3.8 percent to 3.3 percent by 1993	3.4	3.1
2. Reduction of total fertility rate from 7.9 (no target specified)	6.7	5.4
3. Reduction of under-five (child) mortality from 140 per 1,000	91	96
4. Reduction of maternal mortality	na	na
Additional Goals	1989	1993
1. Reduction of rural-urban and rural-rural migration	a	a
2. Motivate males to adopt and practice family planning	a	a
3. Improve women's access to:		
—higher education	b	b
—remunerative employment (modern sector) from 17.8%	20.9	23.1
4. Promote IEC activities	b	b
5. Ensure availability of contraceptive services (improved CPR)	27	33
6. Enhance counseling, examination, and follow-up of contraceptive users	Significant	Significant
7. Train service providers	a	Significant

na=information not available.

^aNot significant.

^bPartially successful.

tion growth rate. The population growth rate had been expected to decline from 3.3 percent in 1969 to 3.0 percent by 1979; instead an increase to 3.8 percent was recorded. Drastic declines in mortality, particularly child mortality, undermined the expected decline in the population growth rate.

The ineffectiveness of the population policy during this period was the result of several factors:

—The population policy was developed and adopted with minimal local input and little or no public discussion by policymakers, opinion leaders, or the general population. The formulation of a population policy with an economic rationale and with high-profile external influence so soon after political independence generated political opposition to the policy and the subsequent family planning program.

—Population growth was perceived by policymakers and bureaucrats as a purely medical concern. The MCH/FP program emphasized improving maternal and child health and ignored providing family planning services or generating demand for the services.

—The decision to make the Ministry of Health the sole implementer of the policy impeded the effective involvement of other key government ministries and agencies. The involvement of other agencies concerned with family planning would likely have provided additional avenues for those willing to use contraception to implement their decision.

—Given the perception that the population issue was a medical one, the family planning program was clinic-based. This imposed various restrictions on the population in terms of accessibility: potential users had to travel long distances to reach family planning facilities, and the waiting time at the clinics was long due to the shortage of personnel. These constraints constituted a major barrier to the acceptance of family planning. As documented by results of the 1977/78 Kenya Fertility Survey, only 7 percent of women of reproductive age were using family planning methods, ten years after the official adoption of the policy.

—The opposition of Christian and Muslim religious leaders to the provision of modern family planning methods hampered efforts to increase the acceptance of family planning. They felt that the use of modern family planning methods was against the will of God and, if widely accepted, would undermine the social and moral fabric of the society.

—Widespread pronatalist attitudes hindered the effective implementation of the policy. The desired family size by 1978 was high, children were highly valued as economic and social assets, and the benefits of having children were believed to far outweigh the costs. Children provided security in old age, guaranteed lineage survival, and provided the needed labor for agricultural and domestic activities.

—The government's commitment to provide free health and education services to the eligible population reduced the real costs of these services at the family and individual levels. This strengthened the general pronatalist attitude among the population.

—Apart from the economic shocks arising from the oil crises in 1974 and 1978, the economy continued to thrive. The negative impacts of the high population growth rate were not always evident.

The World Bank also documented the following reasons for the ineffectiveness of Kenya's population policy from 1967 to 1979:

The first 10–15 years were devoted to creating [a] basic MOH network of facilities and staff. Primary health centers were scattered throughout the countryside to provide MCH/FP services for those who desired them. It was essentially a passive, clinic-based system operated by medical personnel. Efforts to create an outreach program did not get very far. Logistics, IEC, research and evaluation components of the program were weak and often neglected. (World Bank 1992: 50)

Finally, the 1977/78 Fertility Survey underscored the lack of effective information, education, and communication strategies during this period:

In general, it appears that attitudes of Kenyan women toward fertility control are negative. A dramatic change in the general attitude toward family planning will only come if there is an intense and far reaching national commitment to educate women, create work responsibilities outside the home, and encourage the social acceptability of small families. (CBS 1980: 143)

The 1980–89 Period

Implementation. By 1980, economic stagnation made it clear to policymakers in Nairobi that something more drastic had to be done to control the rate of population growth. The major bilateral and multilateral donors that had been urging Kenya to implement an effective family planning program were becoming impatient. The World Bank in particular, which had been providing assistance for Kenya's MCH programs, began to put considerable effort into convincing Kenya's leaders of the importance of reducing population growth. In 1974, the Bank had been able to persuade the government to launch a major family planning effort to which the Bank provided the major share of support. Other activities of the Bank included policy dialogue, sector work, and conditions attached to Kenya's second structural adjustment loan.

These critical activities were designed to "persuade" the Kenyan government to create a coordinating agency for population activities outside the health ministry, to get Kenya to integrate family planning into the "mainstream" of Ministry of Health projects, and to motivate officials to "liberalize" the rules applicable to birth control. A 1992 World Bank report summarized the Bank's contribution to the Kenyan program as follows:

Starting in 1974, four projects have been funded. The first two provided funds to the Ministry of Health (MOH) to establish a network of rural health facilities and training schools; family planning components in these projects were weak and largely ignored during implementation. During this period, the population growth rate actually increased. The third and fourth projects have had more substantial components related to population and family planning, but were initiated

too late (1988 and 1989) to have influenced the change in fertility trends. The second strand of Bank inputs has involved policy dialogue, sector work, and efforts to influence the evolution of the programme in a variety of ways. Examples of the latter included successful efforts to persuade the Government to establish an interministerial coordinating agency for population outside the MOH (included as a condition in the second structural adjustment loan), and then provide it with more responsibilities; and efforts to persuade the MOH to liberalise guidelines for providing contraceptives, to integrate FP into the mainstream of MOH activities, and to offer sterilisation services. Both strands of work have been important components of an overall package that included technical assistance and commodity support from other donors and, perhaps most important, clear signals from Kenya's president that family planning was to be taken seriously. Could the Bank have done anything to speed up this process? While far more effort could have been made to develop effective IEC, outreach, monitoring, evaluation, and research components, the Bank pressed the Government fairly strongly on many of these issues and seems to have taken advantage of opportunities as they emerged. (World Bank 1992: 5)

Institutional Capacity-Building. This period witnessed the creation of the National Council for Population and Development (NCPD) in 1982. The NCPD was given a comprehensive mandate for formulating population policies and strategies and coordinating population activities aimed at reducing the country's population growth rate. Its specific terms of reference included:

- to determine priorities in the field of family planning and population and development activities in relation to the social and economic policies of the government;
- to advise the government on national population policy, including general planning and application of available financial resources;
- to plan, supervise, and coordinate an interagency, multimedia information and education program aimed at spreading family planning knowledge and practice and improving maternal and child health;
- to promote public understanding and acceptance of the concept of family planning and small family size and to promote research into the social, cultural, and economic aspects of population planning and development;

Exercising its mandate to oversee the implementation of the population policy, the NCPD initiated interministerial collaboration and sought the participation of nongovernmental organizations. The NGOs—such as the Family Planning Association of Kenya and the Christian Health Association of Kenya—were invited to provide supportive clinic-based services, IEC campaigns, and community-based services.

Given the fact that the creation of the NCPD was driven by external forces (donors), the Council started off with severe constraints when it came to enticing nongovernmental organizations and government ministries to participate in the population program. There were some reservations about the role of the Ministry of Health vis-à-vis the Council, and the Council staff lacked expertise in population dynamics. In spite of these constraints, the Council gradually

gained the trust of NGOs. Family planning subcommittees at the district level were used to sensitize policymakers and bureaucrats. Population experts in various technical committees assisted by providing guidance. By the end of this period, several ministries were involved in the program. A 1988 evaluation report noted that the NCPD had been most successful where its operations improved coordination of the national population program and somewhat less successful when its operations increased centralized control over components of the programs (Phillips and Kiragu 1988: 116).

The government formulated a District Focus for Rural Development Strategy in 1983. This strategy aimed at decentralizing development planning, budgeting, and supervision and coordination of the government's development activities at the district level. District Development Committees were established as primary policymaking organs as well as monitors of project implementation. In 1985, following the successful organization of the first leaders' conference in Nairobi, the NCPD established District Population Offices to facilitate the decentralization of the population program. A subcommittee on population and family planning was also set up in each district with the responsibility of monitoring the population policy agenda and developing district population plans.

Resource Availability. The 1980s saw further increases in the number of health facilities, particularly during 1985–90. The period from 1980 to 1985 was affected by adverse economic conditions, which resulted in the deceleration of the growth rate of the GDP and hence in government revenue. In this period donor demand grew for the implementation of structural adjustment programs.

Political Will and Commitment. With the realization that socioeconomic development was being hampered by rapid population growth, serious discussions regarding the population issue were initiated. Two leaders' population conferences were held, in 1984 and 1989. These conferences, which brought together policymakers, bureaucrats, religious leaders, and community leaders, were instrumental in shaping political opinion and commitment. Then-Vice President Mwai Kibaki made the following comments at the 1984 conference:

Kenyans have no choice but to control the galloping population. . . . It is logical that if we do plan all other aspects of our life, food production, expansion of health facilities, development of education opportunities, greater productivity in agriculture and industry, then it must surely be rational, logical and necessary that family size itself be planned.

However, a substantial proportion of leaders were still hesitant to give public support to government initiatives to control the population growth rate. There was concern about the impact of the population program on the size of various tribal groups. Others felt there was no land shortage to warrant curbing the population growth rate, despite the fact that only one-third of the land has agricultural potential.

The Kenyan government became a signatory to several international agreements. It endorsed policies and action plans agreed upon during the In-

ternational Conference on Population held in Mexico in 1984 and the World Conference on Women held in Nairobi in 1985. It signed a statement on population stabilization in June 1985.

Service Delivery Strategies. The Ministry of Health continued to provide most of the family planning services. Community-based distribution programs were launched and a program of subsidized sale of contraceptives in urban areas was initiated. The participation of NGOs, women's groups, and private health providers was actively promoted and enhanced. However, the service delivery remained dominantly clinic-based. A 1989 survey of contraceptive availability in 11 districts showed that 93 percent of respondents were within three hours' travel time to a source of family planning services, with the majority (68 percent) indicating a government hospital or clinic and a sizable minority (28 percent) citing field educators or family planning distributors as the source of supply. The study also showed that these sources started providing contraceptive services around 1983 (Hammerslough 1992)

Monitoring and Evaluation. The issue of effective monitoring and evaluation was addressed in detail in the 1984 policy guidelines. Most agencies, including the Ministry of Health, were instructed to set up reliable management information systems. A population census and a Demographic and Health Survey were carried out in 1989.

Effectiveness of the Policy. As observed earlier, this period started off with the revelation from the 1979 census that the population was growing even faster than had been projected. Future socioeconomic prospects were threatened, and the need to effectively address the population issue became paramount. It was also during this period, however, that the initiation of a demographic transition became apparent (Cross, Obungu, and Kizito 1991; Kizito et al. 1991: 4–7), with sharp declines in both the TFR and the population growth rate (see Table 4.5). This unexpected turn of events was facilitated by several factors:

—The government recognized that the population problem was multidimensional and complex. A comprehensive implementation framework that entailed diversity in the relevant agencies became a paramount strategy.

—Campaigns to sensitize political and religious leaders and bureaucrats, carried out in 1984 and 1989, exposed leaders to the challenges posed by a rapid population growth rate and constraints experienced in effectively implementing the family planning program. The recommendations made by leaders provided a springboard for political mobilization of the population in support of the family planning program.

—The expansion of the service delivery system improved access to family planning services. The contraceptive prevalence rate increased from 7 percent in 1980 to 27 percent in 1989.

—The resource base was strengthened by tapping financial and material support, particularly from the World Bank, USAID, and UNFPA. This buttressed the establishment of more family planning facilities, research activities, training of personnel, and dissemination of research findings.

—Enhanced monitoring and evaluation activities assisted in improving the program by identifying major constraints and gaps (CBS 1984; NCPD 1989).

—The total fertility rate declined to 6.7 and the desired number of children decreased to 4.8 by 1989 as compared to 8.1 and 6.5 in 1977/78 respectively.

Although appreciable achievements were realized in reducing fertility and the population growth rate, the envisaged targets were not fully met. Factors such as inadequate resources provided to the family planning program, inadequate participation of men in the program, and minimal attention given to the needs of youth still constrained the effectiveness of the family planning program.

The goal to reduce rural–urban and rural–rural migration was also not met. The rapid increase in the rural population necessitated accelerated migrations. The population in the major urban centers grew faster than had been anticipated. However, the 1979–89 period provided the initial impetus and a conducive environment for effective implementation of the policy. Both political and socioeconomic forces enhanced policy effectiveness.

The 1990–93 Period

Institutional Capacity-Building. The NCPD continued to enjoy supreme authority in the management of population activities. However, the provision of family planning services remained primarily the responsibility of the Ministry of Health. The participation of the NGO community was sustained and encouraged.

Resource Availability. An appreciable increase in the number of health facilities was realized during this period. The number of hospitals increased from 268 to 309, the number of health centers almost doubled, and the number of dispensaries increased by 45 percent. This expansion was the result of effective collaboration among NGOs, the government, and the communities at large (particularly community contributions to self-help projects). In spite of this development, the number of health personnel—particularly those involved in family planning activities—remained inadequate.

Political Will and Commitment. With the advent of a multiparty democracy during the early 1990s, the various political party manifestos in 1992 underscored the importance of curbing the rapid population growth rate. Each of the political parties addressed the population growth issue.

Service Delivery Strategies. The service delivery system remained predominantly clinic-based and mainly under the control of the Ministry of Health. The role of community-based programs was further enhanced.

Monitoring and Evaluation. The activities initiated during 1980–89 to create effective management information systems were accelerated. A Demographic and Health Survey was carried out in 1993 to ascertain levels of fertility, infant and child mortality, and the contraceptive prevalence rate.

Effectiveness of the Policy. The period after 1989 saw a continued reduction in fertility and population growth rates and an increase in contraceptive use, as shown in Table 4.5. By 1993 the total fertility rate had declined to 5.4, the contraceptive prevalence rate had increased to 33 percent, the desired number of

children had declined to 3.7, and the population growth rate is estimated to have declined to 3.2 percent (NCPD 1994). On the other hand, the unmet need for family planning services had increased and the reproductive health issues of youth had not been addressed—largely because of the attitudes of religious leaders and policymakers. Issues pertaining to women's empowerment had not received the attention they deserved.

Legal Perspectives. Until 1983, the provision of family planning services—particularly prescriptions—was the domain of medical doctors. This restriction constrained the availability of services in rural areas, where the majority of the population live. The role of nonphysician health personnel in the provision of family planning services was enhanced through the repeal of the Nurses, Midwives, Health Visitors Act in 1983, which had previously hampered their effective involvement in the provision of family planning services. The Act (No. 3 of 1983) provided for the training, registration, enrollment, and licensing of nurses and midwives to ensure their maximum participation in the provision of health services, including family planning.

The laws related to the manufacture, sale, advertisement, and use of contraceptives have been favorable since 1983. Today, no taxes or duties are imposed on the procurement of materials to manufacture contraceptives and on their sale. The laws related to abortion emphasize that procuring or facilitating abortion is illegal unless the mother's life is in jeopardy.

Lessons Learned, 1967–93

It is now generally accepted that Kenya has entered a period of sustainable fertility decline along with Botswana and Zimbabwe in east and southern Africa. The Kenyan fertility decline probably began in the early 1980s, but certainly no later than the mid-1980s. John Caldwell has observed that the most favorable socioeconomic indicators for reaching the threshold of decline appear to be at least 89 percent of all children born surviving to five years of age and at least 30 percent of adult girls attending secondary school. He also noted among the indicators (a) an adequate national family planning program with over 25 percent of currently married women practicing family planning employing modern methods; and (b) the backing of government, especially the head of state, encouraging women to practice family planning so that, even in male-dominated societies, they increasingly assume responsibility for contraceptive decisionmaking (Caldwell, Orubuloye, and Caldwell 1992; Caldwell and Caldwell 1993). This set of conditions was reached in Kenya in the early 1980s.

Kenya has always been fortunate in having donor resources readily available for its population and family planning efforts. Why, then, did it take so long before the fertility rate began to decline? In the first place, it is almost certain that Kenya underestimated the magnitude of the problem when it formulated its population policy shortly after independence. This is partly explained by the highly visible influence of foreigners in the policy formulation and program implementation stages and the absence of public debate on the

issue of population growth. Second, the infrastructure needed to be put in place to effect the declines in infant and child mortality and to educate girls beyond primary school level. Third, the political leadership needed to change so that a president was chosen who was supportive of the policy and gave leadership and direction to the family planning program, making it possible to develop and implement strategies for increasing the accessibility of family planning information and services. Thus, although the population policy was ineffective from 1967 to 1979, the health and educational policies were extremely successful. The success of the health policy compounded the population problem and brought it to the attention of policymakers. The success of health, education, and economic policies created the conditions that produced the decline in fertility during the 1980s.

The efficacy of implementation strategies has varied over the years. The perception during 1967–80 that the population issue could be addressed effectively by the health sector alone was unrealistic, given the demands on that sector. Hence, the establishment of the National Council for Population and Development as a coordinating body and the effective involvement of NGOs and other government ministries enhanced the implementation of the policy after 1984. Perhaps the most important lesson learned from the implementation phase is that the implementation of population policy requires public involvement, commitment of resources, and the political support to forge ahead with the agreed-upon agenda. A population policy, like any other public policy, should also be comprehensive and consistent in content; should promote the development of an appropriate institutional infrastructure; and should have a timetable for expected targets, with precise and realistic expectations in terms of demographic, socioeconomic, political, and cultural environments.

The measurement of the population policy's effectiveness seems to have been driven by the envisaged targets and the efficacy of the implementation strategies. With the exception of the rate of population growth, the policy remained vague about the precise level of fertility to be achieved at each point in time (except for the partial revision made during the leaders' conference in 1989) and about the indicators to be used to ascertain the achievement of socioeconomic and family planning goals. These gaps have precluded a strictly objective measurement of the policy's effectiveness.

THE POPULATION PROBLEM TODAY AND PROPOSED SOLUTIONS

Although the prior analysis of policy prescriptions and the assessment of how they were implemented and achieved have provided some insight into pertinent issues, this study would not be complete without seeking the views of affected constituents. Interviews were held with executives of NGOs, government bureaucrats/technocrats, religious leaders, and end-users on several issues.

Interviews without prior selection were held with many of the executives of NGOs involved in the population program. Bureaucrats/technocrats within

the government were selected on the basis of their involvement in the implementation of the population policy as collaborators with the National Council for Population and Development. The study included religious leaders of Christian, Muslim, and indigenous groups. The Central Bureau of Statistics' national sample master frame was used to randomly select households in Nairobi, South Nyanza, Kakamega, Meru, Nyeri, and Kilifi. These areas represented districts where fertility was high (Kakamega and South Nyanza) and districts where significant declines in fertility had occurred (Meru and Nyeri). Nairobi was included to represent the urban environment.

Perceptions of the Most Challenging Problems

Nearly half (45 percent) of the implementers (NGO executives) and bureaucrats perceived the major problem as being an economic crisis, followed by the rapid population growth rate (32 percent), unemployment (22 percent), poverty (14 percent), and political instability and food shortages (12 percent).

Sixty-five percent of the religious leaders perceived the problem as being an economic crisis, followed by large population size (26 percent), threat of diseases (particularly HIV/AIDS), high cost of medical services, inadequate education and political instability (22 percent), and unemployment (17 percent).

The end-users, regardless of age and sex, did not list rapid population growth or population size among the problems facing the country. The biggest challenge to them was the economic crisis, particularly the high inflation rate, political instability, food shortages, and unemployment (mostly among men). The survey was carried out at a time when the country was facing numerous economic and political challenges, which perhaps influenced views of end-users.

Defining the Population Problem

The current definition of the population problem was diverse in the views of policymakers, implementers, and end-users. About 60 percent of the implementers and bureaucrats/technocrats believed the population problem was very serious. They felt that the population growth rate was above sustainable levels as far as the economic base of the country was concerned, and they narrowed the problem to high fertility. This perception echoed the government's underlying concern over its inability to meet the population's basic needs.

The religious leaders endorsed the view that the population problem was very serious (about 50 percent of the respondents). They felt that the problem had been caused by a high population growth rate and inadequate family planning services.

The end-users, on the other hand, perceived the population problem to be predominantly the large population size and the high birth rate, as shown in Table 4.6.

These perceptions explicitly and implicitly define the current population problem as a high population growth rate that cannot be sustained, as reflected by Kenya's prevailing adverse socioeconomic conditions.

Table 4.6 Percent distribution of end-users' perceptions about population issues facing Kenya, according to age group and sex

Type of Problem	15-24		25-29		30-34		35-39		40+	
	Men	Women	Men	Women	Men	Women	Men	Women	Men	Women
Large population size	75	65	62	58	63	66	73	75	60	67
High population growth rate	—	2	—	2	—	6	4	—	4	1
High birth rate	13	8	11	5	2	8	2	3	8	7
Population has been controlled/not a problem	—	9	13	16	19	10	10	6	9	6
Don't know	—	1	—	3	2	2	—	3	1	1
No comment	—	5	9	7	4	5	6	8	7	6
Other	12	10	5	9	10	3	5	5	11	12
Total percent	100	100	100	100	100	100	100	100	100	100
Total number	8	97	47	114	54	96	51	71	143	88

Perceptions of the Effectiveness of the Government's Response

The majority of the bureaucrats/technocrats, implementers, and religious leaders underscored the fact that the government had been in the forefront in building family planning facilities and providing services. The implementers, particularly those from the NGO community, indicated that the government had not addressed the issue of youth access to family planning information and services. They also felt that the government had allocated minimal financial resources to the population program. A little more than half of the end-users who were interviewed—about 51 percent of the men and 54 percent of the women—praised government efforts to provide free family planning services, as highlighted in Table 4.7.

Perceptions of the Role of NGOs

The role of NGOs in implementing the population program was viewed as complementary to government efforts by bureaucrats/technocrats, religious

Table 4.7 Percent distribution of end-users by opinion on how Kenya's government was addressing the population problem

Opinion	Men (N = 303)	Women (N = 466)	Total (N = 769)
Provides free family planning services	51	54	53
Provides information on family planning through newspapers, <i>Barazas</i> (community meetings), radio, and TV	10	9	10
Has built hospitals/clinics	1	3	2
Has employed family planning agents	2	2	2
Organizes seminars on family planning	3	3	3
Other	33	29	30
Total	100	100	100

leaders, and the NGO executives themselves. They participated in IEC programs, service provision, personnel training, and research.

Perceptions of the Role of End-Users

The bureaucrats, NGO executives, and religious leaders whom we interviewed acknowledged that individual end-users expressed an awareness and acceptance of family planning. Participation in community-based distribution programs was cited as a major contribution that individuals were making to the program. Religious leaders considered women to be more concerned and involved than men, which was viewed as a major bottleneck given the power that men have in imposing their opinions on decisions pertaining to population dynamics.

Interviewees’ Proposed Solutions

The survey of end-users and other participants revealed few reasons for the ineffectiveness of population policy during 1967–80 or for its effectiveness during the later period. The responses indicate that current circumstances seem to be in harmony with the policy prescriptions, hence the policy is expected to continue successfully. The interviewees made various suggestions when they were asked for opinions on how the government should approach the population issue. Table 4.8 shows the views expressed by NGO executives.

Recommendations specified in the table emphasize the importance of IEC, integration, funding, and socioeconomic development.

The majority of the bureaucrats/technocrats made the following recommendations:

- Incorporate family planning into the school curriculum.
- Include a family planning program in the development plan with a clear indication of the allocated resources.

Table 4.8 Specific recommendations by Kenya’s NGO executives

Recommendation	Percent
Create more awareness through IEC	42
Focus activities on both men and women, including youth	33
Government should become more articulate in involving the MOH and other ministries	25
Increase funding to the population program	21
Educate opinion leaders on population issues and urge them to educate the public	21
Influence traditional societies through outreach programs to enhance local participation	21
Improve the standard of living of the people by providing high-quality health care services, training people in small-scale businesses, and developing sparsely populated areas	21
Increase the number of Population Program Officers	17
Conduct more research in family planning and disseminate findings to implementing agencies	17

- Strengthen District Population Committees by providing more trained personnel and equipment, such as vehicles.
- Encourage local people, especially men, to participate more actively in population programs.
- Assign a Population Officer to each district and each division.
- Stress basic health for program success.
- Develop clear government legislation on the number of children a couple should have.
- Intensify programs, particularly community-based distribution programs.
- Eradicate traditional practices such as polygamy and sex preference of offspring.
- Tax large families and give incentives to small families.
- Effectively monitor funds allocated to population programs.
- Initiate income-generating projects so that the population program can be self-sustaining after donor support is withdrawn.
- Establish population departments in the following ministries: Culture and Social Services; Labor and Manpower Development; Health; Agriculture, Marketing, and Livestock Development; Environment and Natural Resources; and Education.
- Establish collaboration, to be well coordinated by the Ministry of Planning and National Development.
- Incorporate local interests and cultural values in the service delivery and information strategies.

Bureaucrats and technocrats believed that the future success of the population program depends on availability of resources, integration of the family planning program into other programs, and effective community participation.

Religious leaders made the following recommendations:

- Educate the general public to understand their role and responsibilities with regard to the population issue.
- Promote lectures and seminars on development and population issues.
- Expand educational facilities, particularly technical institutions.
- Increase funding to the population sector.
- Enhance participation and collaboration among the government, NGOs, and religious groups.
- Provide more trained personnel who can travel from house to house to promote awareness of family planning and to recruit men into the program.
- Build more industries in rural areas and improve the infrastructure in order to provide employment.
- Offer incentives such as education and health service subsidies to those with small families.

End-users recommended promotion of IEC activities, building more clin-

ics, and providing more field personnel. They asserted that these provisions would make their use of family planning methods easier or likelier.

Various respondents concurred that the most important issues to be tackled in the future were the establishment of more family planning facilities, recruitment of more personnel, enhancement of IEC programs, and availability of adequate financial resources. Some emphasized improvements in institutional collaboration and enhancement of community participation.

Table 4.9 integrates the recommendations made by the various interviewees to highlight areas of concurrence.

Table 4.9 Proposed solutions to Kenya's population problem, as expressed by the interviewees

Recommendation	NGO executives	Bureaucrats/ technocrats	Religious leaders	End-users
Create more awareness among the general public through IEC	X		X	X
Focus activities on men, women, and youth	X	X	X	
Involve the MOH and other ministries	X	X		
Increase funding to and intensify the population program	X	X	X	
Educate opinion leaders on population issues	X			
Use outreach strategies to influence traditional societies and enhance community participation; incorporate local interests and cultural values within service delivery and information strategies	X	X		
Provide high-quality health care	X	X		
Increase the number of Population Program Officers	X	X		
Step up research on family planning and disseminate findings to implementing agencies	X			
Incorporate family planning into the school curriculum		X		X
Include family planning in the development plan		X		
Strengthen District Population Committees with more trained personnel, materials, etc.		X		
Introduce legislation on acceptable number of children per family		X		X
Eradicate traditional practices such as polygamy and sex preference of offspring		X		
Monitor funds allocated to the population program		X		
Establish/encourage multisectoral collaboration		X	X	
Expand educational facilities, especially technical institutes			X	
Increase number of trained family planning personnel, especially fieldstaff			X	X
Promote socioeconomic development and improve the rural infrastructure	X		X	
Offer incentives to small families and family planning users		X	X	X
Build more family planning clinics				X

RECOMMENDATIONS

This review of Kenya's population policy comes at a propitious time. The agenda agreed upon at the 1994 International Conference on Population and Development expanded the scope of the population issue beyond family planning programs to issues pertaining to its integration into development strategies; to gender equality, equity, and the empowerment of women; to the environment; and to reproductive health. Moreover, Kenya's long-awaited fertility transition is underway. These developments pose diverse challenges for the formulation of future population policies. The findings presented in this report provide useful insights into the challenges faced during the evolution and implementation of policy to date. The proposed expanded role of Kenya's population policy is discussed below to indicate implications for future policy-making.

Policy Formulation

- Bureaucrats, implementers, religious leaders, and end-users concur that the cardinal objective of further reducing the population growth rate and overall fertility to sustainable levels is critical for individual and societal wellbeing. This concern should constitute the core of the future policy framework. Substantial improvements in the design and implementation of family planning programs will be required to guarantee easy access to good quality services.
- Meeting the family planning and reproductive health needs of adolescents is a great challenge. Policy should articulate appropriate IEC and service delivery strategies to enhance youth participation in population programs.
- Women's empowerment should be emphasized, particularly the enhancement of female educational attainment and access to remunerative jobs.
- Policy should address issues pertaining to migration and urbanization, specifying acceptable migration and urbanization patterns.
- Given the AIDS pandemic, it is of vital importance that reproductive health issues be included in the policy framework.
- Attempts made in 1984 and 1989 to establish targets for various components of the policy should be improved upon by assuring that appropriate indicators of progress are stipulated. Future monitoring and evaluation systems should collect data on fertility and mortality levels (particularly child mortality). Socioeconomic data should include educational attainment, school enrollment, access to and affordability of reproductive health services, contraceptive prevalence rates, and government and family expenditures on social services. This will provide a yardstick for measuring performance and create a sense of responsi-

bility and accountability among implementing agencies and the public sector in achieving their assigned goals.

Implementation

Successful implementation of future policies will depend heavily on the following factors:

- Adequate domestic resource allocation to the population sector will be required, in order to enhance political will and commitment to the population program. The current dependence on international donor funds is not a healthy situation.
- The establishment of more family planning and health facilities, as well as the recruitment and training of additional personnel to satisfy the demand for family planning and health services, will assist in implementing the policy.
- The IEC program should be expanded and improved to reach the majority of the population, with special emphasis on youth and men. More culturally relevant strategies should be developed such as the production of IEC materials in various languages and the use of posters that realistically depict fertility-related behavior and needs in various communities.
- Education for girls and women and participation in income-generating activities for women should be stressed by providing more secondary-level educational facilities, technical training, and access to credit facilities. This will require the effective participation of the educational, industrial, and commercial sectors, among others.
- Community-based programs should be encouraged for effective public participation in the implementation of the policy. The drastic decline in the desired number of children during the last decade has created a conducive environment for implementing family planning programs. This opportunity should be fully exploited.
- Monitoring and evaluation activities should be enhanced in order to provide up-to-date insights into the performance of the population program.

FUTURE PROSPECTS

End-users' Aspirations

In response to adverse socioeconomic conditions affecting the population, Kenyans have opted for lower fertility, as evidenced by the current demographic transition. End-users' aspirations to achieve higher socioeconomic status, higher education for their children, and better health for their families provide the requisite environment to accelerate demographic transition.

Developments After the International Conference on Population and Development

Since the International Conference on Population and Development, the Kenyan government has taken important steps to sensitize policymakers and implementers on the actions agreed upon at the conference, and has subsequently prepared a revised "National Population Policy for Sustainable Development." This Sessional Paper has been cleared by the Cabinet and has been tabled in Parliament for ratification. The sensitization process entailed formal presentations of the conference report, with emphasis on the actions expected to be taken by governments to achieve stipulated goals and targets. The deliberations during the presentations set in motion the preparation of the draft revised policy document.

In contrast with the previous tendency for the government to formulate population policy without the involvement of diverse groups, the current policy has been formulated in collaboration with various stakeholders. UNFPA-funded national workshops and regional seminars, held in 1995, solicited input from a variety of constituents. This change of approach was designed to include the input of NGOs and the public in order to alleviate suspicions that previously undermined the commitment essential for effective policy implementation.

The revised policy acknowledges the ineffectiveness of the 1967 policy and the substantial achievements that have been made since 1984. It takes into account other relevant policies: the health policy framework (ROK 1994), the reproductive health strategy, and policies on advocacy and IEC in setting the targets to be achieved by the year 2010.

The Kenyan government plans to assume responsibility for providing a greater proportion of required resources for implementation through budgetary allocations to relevant ministries. However, the private sector and the general public will also be encouraged to share the cost of the program. The role of international donors (World Bank, UNFPA, European Union, DFID, USAID, GTZ) in the implementation of the policy is mainly envisaged to be the funding of various activities and provision of technical support.

CONCLUSION

Kenya's first and subsequent population policies have been justified largely on neo-Malthusian rationales that defined development in socioeconomic terms and predicted dire consequences for society as a whole if the country's population growth rate was not brought into line with its resource capacity. It also emphasized government responsibility in establishing vigorous family planning programs to reduce fertility. This is consistent with the prevailing international politics of population, which in the 1960s regarded high population growth rates in the third world as an urgent global problem and recommended population policy as a significant vehicle for economic development. It was

also believed that large-scale family planning programs offered a feasible and cost-effective policy response. The population control advocates had their greatest concentration in the United States with institutions such as the Population Council playing a leading role. Thus Kenya's population policy in the mid-1960s was a testing ground in sub-Saharan Africa. The presentation and implementation of the policy, however, was based largely on the maternal and child health benefits of family planning because of the fierce opposition to the policy.

Donald Warwick (1982) has noted that the belief in the effectiveness of voluntary family planning as an instrument of policy was based on simplistic assumptions about the economic and social roles of children in developing countries, the motivation of women to use contraception, and their ability to make independent decisions about childbearing, to find sources of self-esteem outside the family, and to communicate freely with their husbands about fertility control. Throughout the 1960s and 1970s Kenya's family planning program proved to be weak and ineffective as an instrument of policy implementation. Even when Kenya's population growth rate became the highest in human history and there was external pressure to reduce the rate of growth, it is to Kenya's credit that there was never a temptation to adopt an involuntary or coercive family planning program or to introduce incentives as a means of increasing the effectiveness of the policy.

Between the time Kenya articulated its first population policy in 1965 and 1975, only four other sub-Saharan African countries had adopted an official population policy. During the 1970s and 1980s, the most remarkable changes in the development of population policy occurred in sub-Saharan Africa. By 1988, 32 countries had adopted or were in the process of developing an official policy to limit their population growth. This widespread adoption of population policies resulted in part from the conviction of governments that their population was growing at an unprecedented rate far beyond their resource capacity, but also from subtle and sometimes overt pressure from bilateral and multilateral donors. Empirical evidence was also beginning to suggest that the adoption of a policy alone had only limited effect on fertility behavior unless it was supported by wider policy measures and greater availability and use of family planning services.

Despite the ongoing fertility transition in Kenya, the population is projected to increase from the current 25 million to over 54 million by 2050. More than half of Kenya's population is below the age of 20. Such a youthful age structure carries with it a substantial momentum. Kekovole (1996) estimates that by 2050, population momentum would have contributed 68 percent of the population growth since 1995, far greater than the 26 percent that would result from unwanted fertility and the 6 percent from high desired family size. There are no simple policy options to reduce the impact of momentum effectively. Increasing female education and helping adolescents to avoid early pregnancies by providing them with information and family planning and reproductive health services offer the most practical and humane options.

Throughout human history and in virtually all societies, women with unwanted or unplanned pregnancies have turned to induced abortion to avoid unwanted births. Where abortion is legally restricted, as in Kenya, the proportion of abortions that are unsafe is high. Despite the lack of reliable statistics, it is reasonable to estimate that because of the rapid increase in contraceptive use in the last decade and a half and because no reversible contraceptive is 100 percent effective in practice, unsafe abortion has played a significant and probably underestimated role in Kenya's fertility decline. Although equally difficult to quantify, Kenya has a high prevalence of sexual coercion and abuse of women. This includes sexual abuse within marriage and abuse of minors. In addition to the violation of basic human rights, a significant proportion of the abuse results in unwanted pregnancy. Estimates vary, but unsafe abortion may be responsible for as much as 25 percent of maternal morbidity and mortality in Kenya. The situation appears to be worsening and public discussion of the issue is almost nonexistent. Although it is likely that improved quality and access to family planning services would reduce high rates of abortion, even widespread and high-quality family planning services will not eliminate the demand for abortions. Because the majority of users of contraceptives obtain their supplies through government sources, it is important that women, especially poor women, who have signified their intention to limit their fertility through use of contraception are not condemned to resort to illegal and unsafe abortion.

The findings of this study have underscored the need for a comprehensive and integrated policy framework that includes all the requisite ingredients. The most important lesson learned, which other sub-Saharan African countries can emulate, is that policy formulation and implementation are dynamic processes and that the mobilization of political and public commitment, availability of resources, institutional development, effective monitoring and evaluation strategies, and accelerated socioeconomic development constitute the major components of an effective population policy.

Kenya's rate of population growth is poised to decline further. The investments made in education, health, and family planning programs provide a solid basis for a sustainable decline in fertility. However, substantial additional investments will need to be made in the family planning program to address the unmet need for contraception and to address the overlapping issues of family planning and sexually transmitted diseases and HIV/AIDS transmission. In particular, in the light of the ICPD plan of action, Kenya's policymakers will have to address three issues more directly and effectively: adolescent sexuality, unsafe abortion, and sexual coercion and abuse. The three issues have a common, human rights foundation and they remain highly emotive and sensitive subjects in Kenya.

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Notes

1. Although the colonial administration recognized the importance of reliable population statistics for policy and planning, the censuses conducted in 1911, 1921, 1926, and 1933 did not attempt to enumerate Africans and Somalis.

2. The team consisted of R. K. Anderson, Director of Technical Assistance, Population Council, as Team Leader; Ansley

Coale, Director, Office of Population Research, Princeton University; Lyle Saunders, Program Associate, Population Program, Ford Foundation; and Howard Taylor, Chairman, Department of Obstetrics and Gynecology, Columbia University.

3. Kinga is a Swahili word for prevention.

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CARLOS BRAMBILA

Mexico's Population Policy and Demographic Dynamics: The Record of Three Decades

Over the last 30 years, Mexico's demographic dynamics have changed dramatically. The decline in fertility rates in Mexico has been comparable only with declines in Colombia, Indonesia, and China (Nortman 1985; Ross, Mauldin, and Miller 1993). Mexico's fertility began to drop in the late 1960s from 7.0 children per woman—an unusually high level, considering international levels of the period. As a traditional society in the process of industrialization, with a large agrarian population, strong Catholic traditions, and widespread poverty, the country was an unlikely candidate for fertility transition (Urquidi 1989). However, the achievements of the continuously expanding population program are hardly questionable: contraceptive use increased from 30 percent in 1976 to 48 percent in 1982 and 66.5 percent in 1995 (CONAPO 1994 and 1996), and the total fertility rate (TFR) dropped to 2.7 in 1995.

The demographic impact of the family planning program may be observed in the age distribution of the 1990 population, which shows a significant reduction in the size of younger age groups (0–9 years of age) despite a slight decline in the infant mortality rate during the previous decade. Evidence from demographic surveys demonstrates that large shares of the population actively practice contraception, mainly to limit fertility. To achieve its demographic goals, Mexico has undergone radical changes in its political and programmatic approaches. First, political development in Mexico, including the increasing participation of active groups within the civil society, led to a constitutional amendment in the early 1970s establishing the right of couples to regulate their fertility. Second, the constitutional amendment initiated a process of institutional development in which agencies directly involved with population issues have undergone continuing consolidation and expansion. Third, population

programs have evolved in conjunction with the provision of health services at large, so their reach has expanded to increasingly larger shares of the population. Fourth, with the consolidation of service provision institutions, new challenges were set to increase their productivity, efficiency, and performance. Finally, by 1994, following the worldwide trend established by the Programme of Action of the International Conference on Population and Development to minimize the demographic emphasis of family planning programs and to direct service provision toward satisfying the reproductive health needs of the population, policies began to emphasize integrated services with a higher public health impact. Reproductive health services are now defined to include the right of all to control their fertility safely and effectively, to have safe pregnancies and deliveries, to have and raise healthy children, to understand and enjoy their own sexuality, and to avoid diseases or death related to sexual or reproductive practices.

This is not to say that the evolution of the Mexican population policy has been smooth. Activists in the field suffered the benign neglect of politicians in the 1960s, survived the ferocious attacks of opponents in the 1970s, and endured the arbitrary usurpation of their functions by bureaucrats in the 1980s. Policies themselves have been restated on several occasions over the last 30 years, oftentimes flying in the face of the needs evidenced by past trends. Programs have also been under considerable strain, aggravated by an active opposition to, and a narrow understanding of the purpose of family planning programs.

Although the Mexican population program has made important advances, it failed to achieve the demographic target, established in the late 1970s, to reach a population growth rate of 1.3 percent by 1995, which it was hoped would lead to an even lower growth rate of 1.0 percent by the year 2000 (CONAPO 1978). Some authors argue that this failure was largely due to a limited understanding of the country's demographic dynamics (Aguirre 1986). However, an hypothesis that has scarcely been analyzed is that the failure to meet demographic targets was largely due to a diminished performance by the national family planning program. Two arguments in favor of this latter hypothesis are the nature of unmet need for contraception, which is discussed in the following sections, and the widening gap between rural and urban patterns of contraceptive use that was observed during the same period (CONAPO 1994; Paz 1993). The 1995–2000 National Population Program has established the following targets: "The goal for demographic growth in the country is to reach a natural growth rate of 1.75 percent by the year 2000 and 1.45 percent in the year 2005. This demographic dynamic entails total fertility rates of 2.4 and 2.1 children per woman, respectively. The level of fertility established for the year 2005 is equivalent to the intergenerational replacement level, which is the goal that commands programmatic strategies in this matter" (CONAPO 1995: 60).

The impressive achievements of the Mexican population control program should not obscure its major flaws and limitations in demographic planning

and implementation. Population policies in Mexico are incomplete, contradictory, and uncoordinated. They are *incomplete* because they have focused mainly on a single demographic variable—fertility—with little or no attention given to migration and urbanization policies (Aguilar 1987). Health and education policies have traditionally been considered public services rather than policy areas, as illustrated by Frenk (1994) for the health sector. (For an alternative view of health policies see Sen, Germain, and Chen 1994 and Castañeda 1992). The policies are *contradictory* because, while major efforts are directed at fertility reduction, other social policies, mainly concerning education, housing, and social security, provide uniform subsidies to families regardless of their size. For example, enrollment in the public education system, educational materials, and subsidized uniforms are provided for all families regardless of the number of children. Designated “social interest” housing units are provided for large families, and financial schemes to subsidize this type of housing are designed by using a family norm of three or four children. Medical insurance is provided free of charge to all families regardless of size. In this sense, these policies provide indirect incentives for higher fertility. Finally, the policies are *uncoordinated* because, although a central body directs all demographic planning efforts, in reality each social and economic sector establishes goals, objectives, strategies, and programs, independent of federal regulations. For instance, regional and urban development policies fail to consider the official demographic targets.

The major obstacle to adequate demographic planning in Mexico is probably the limited capacity of responsible government agencies to implement the proposed programs and to enforce their own policies. Government emphasis on planning has resulted in vast bureaucracies and regulatory offices that communicate with one another only in writing. In short, the Mexican government has, for the most part, done little more than pay lip service to demographic planning. The following brief account of achievements over the last 30 years illustrates the limited success of such rhetoric.

STAGES OF DEVELOPMENT OF MEXICO'S POPULATION POLICY

The Pretransition Years: 1936–50

Along with the process of nation-building during the nineteenth and early twentieth centuries, the Mexican constitutions and laws incorporated a demographic or population component to the extent that they emphasized the need to achieve “national integration,” “colonization” of inhabited regions, “ethnic amalgamation,” and social and economic wellbeing for all nationals without discrimination.

Three factors may be associated with the strong emphasis of Mexico's constitutions on national integration (that is, the incorporation of hundreds of indigenous groups into the social, political, and economic life of the country, including political participation, voting, education, and job opportunities for

indigenous populations). The first factor is the physical geography of the country, which is mountainous and difficult to reach in the south, and desert-like in the north. The geography of the country is such that several rural regions are difficult to reach, stimulating the dispersion of populations and hindering the access that isolated populations have to education and employment (social integration) as well as to transportation routes and the means to make producers and consumers readily accessible to each other (economic integration). The second factor associated with the emphasis on national integration is embedded in the history of the country, which involved massive destruction and the dispersion of large indigenous populations as a result of direct military confrontations between natives and conquerors (Cook and Borah 1971). The third factor is the making of the modern Mexican state, not only as a guarantor of citizens' rights and obligations, but also as a driving force of development and progress (Meyer 1974).

Sandoval (1994) argues that Mexico's population concerns during the early twentieth century resembled those of Italy and Germany in the late nineteenth century in their emphasis on demographic expansion, territorial occupation, and the consolidation of borders and frontiers. According to Sandoval, such demographic aims were especially relevant in the context of the events of the first 100 years of the independent country, which included the loss of half of its territory to an expanding neighbor; ten years of civil war that led to a European intervention; the establishment of an ephemeral empire in the country that unchained guerrilla warfare nationwide; and, finally, an extended period of consolidation of a modern state and economy, which, unable to reduce social and economic inequalities, led to the first social revolution of the twentieth century (González Navarro 1974).

An additional factor that encouraged the pronatalist policies of Mexico's post-revolutionary governments was the large toll in human life taken by the revolutionary violence of the years 1910–21. As noted by McCoy (1974b), during the pre-World War II period population growth was generally regarded as an asset rather than a constraint to development. Finally, the demographic impact of mortality decline was not entirely acknowledged until its consequences were apparent to large shares of the population.

The first Population Law in Mexico, established in 1936, emphasized three main goals: (1) the need to increase population size, (2) the need to populate inhabited regions, borders, and frontiers, and (3) the promotion of education and health services to achieve national integration (Loyo 1960). The demographic drive of this law was justified by the growing demands created by the country's industrial and agricultural development. Compared with the alternative of promoting international immigration to satisfy labor demands, demographic growth of the native population represented the political success of national integration and the effective amalgamation of heterogeneous populations. The need to colonize territories was justified to the extent that large territories such as the northern border area and the Yucatán peninsula remained uninhabited until the second half of the twentieth century, after which rapid

growth began. (Today, northern border cities such as Tijuana and Ciudad Juárez are among the most dynamic in the country. Also, tourist and industrial centers have been developed in the Yucatán peninsula, leading to higher population density there.) Finally, the need to promote education and health services was justified on the grounds of national integration and "ethnic amalgamation" of the numerous indigenous groups dispersed in the national territory.

The first Population Law of Mexico failed to evolve into a formal population program coordinating related activities throughout the country. However, this law facilitated the development of a political and ideological language that valued extended families and high fertility, and that justified several programs related to migration, colonization, agrarian reform, industrialization, health, social security, and education. Activities conducted in this area were supported by the 1936 Population Law, but cannot be considered an articulated strategy derived from the law.

Early population policies were pronatalist to the extent that they discouraged contraceptive use, information, and services through either direct prohibitions or neglect. The instruments of this policy included incentives to large families, increased migration, and restrictions on contraceptive distribution. Among the incentives to high fertility were the provision of family allowances that, in practice, rewarded large families, and active immigration programs to populate the northern states. The restrictions to contraceptive use included the requirement, established by the Sanitary Code, to distribute contraceptives only under medical prescription, restrictions on the manufacture of contraceptives, and the prohibition of family planning advertisements.

The Transition Years: 1950–73

Starting in the 1950s, during the postwar baby boom, demographers anticipated the consequences of rapid growth. "Overpopulation" became a major international concern. Population policies throughout the world became centered around the problem of population growth either in opposition to the principle of population control or in favor of controlled growth (Bondestam 1980).

Mexico remained a pronatalist country during the postwar years, mainly justified by the fact that the rate of economic growth until the early 1960s was twice that of population growth. The large demand for labor in an expanding economy and the perennial need to populate uninhabited regions remained the major political reasons to support a growing population. An additional factor was the idea that a larger population meant a stronger economy, an idea that the state inherited from the Mexican Revolution.

During this period the economic optimism that accompanied rapid economic growth, and the notion that unlimited expansion to uninhabited regions was possible, supported pronatalist governmental policies. The official stand was that governmental policies should aim to improve the standards of living for the entire population and to achieve a just distribution of wealth, rather than reduce the size of the population. During the presidency of Adolfo López Mateos (1958–64), the administration allowed pharmaceutical companies to

produce and market oral contraceptives, and the first private family planning association, the Family Wellbeing Association (*Asociación para el Bienestar de la Familia*), was opened. During the administration of President Gustavo Díaz Ordaz (1964–70), other groups initiated population-related activities, a worldwide population debate was occurring, and the negative consequences of uncontrolled growth were increasingly apparent, so that by the mid-1960s the government faced, for the first time, population growth as a public issue.

During the administration of President Díaz Ordaz, public family planning services became available, though without the aim of controlling population growth. Family planning activities in Mexico date back to 1959 when the Family Wellbeing Association installed the first family planning clinic in the country. Under the new name of *Asociación Pro-Salud Maternal*, the Association implemented three rural programs and a research project on contraceptive development. In 1965, the Foundation for Population Studies (*Fundación para Estudios de la Población A.C.*, FEPAC) started offering contraceptive services through four clinics in Mexico City. By 1974 the Association had 29 centers in the capital city and 69 clinics throughout the country. During the early 1970s, FEPAC was handling 80 percent of contraceptive distribution, prior to the establishment of public services (CELADE and CFSC 1972). FEPAC also pioneered social studies on family planning and abortion in Mexico. Reportedly, the first postabortion contraceptive services were provided at the then-largest maternity hospital in Mexico City, the Women's Hospital (*Hospital de la Mujer*). The Mexican Institute of Social Security (*Instituto Mexicano del Seguro Social*, IMSS) also provided contraceptive services, mainly aiming to control illegal abortion. Finally, other public institutions such as hospitals of the armed forces and the Institute of Social Security for Federal Employees (*Instituto de Seguridad y Servicios Sociales para los Trabajadores del Estado*, ISSSTE) also provided contraceptives.

The Stage of Institution Building: 1973–78

During the early 1970s, under the administration of President Luis Echeverría, the government established the first national family planning service under the general rubric of "responsible parenthood" and "family planning." The major turnabout in population policy was a constitutional amendment establishing that "every person has the right to decide freely, responsibly and on an informed basis, the number of children he or she may have." In December 1973 President Echeverría promulgated the General Law of Population, which initiated a new stage in the history of Mexican population policy. The law established as a general objective the need to "regulate phenomena affecting the population in terms of volume, structure, dynamics and distribution in the national territory, so that it can have an equitable and fair share of the benefits of social and economic development." To coordinate and reinforce population-related activities, the same law called for the formation of the National Population Council (*Consejo Nacional de Población*, CONAPO), with the mandate of regulating all governmental and nongovernmental activities in the field of population.

The idea of population "regulation" along with economic and social regulation may be better understood within the context of the centralized planning ideology prevalent among post-revolutionary policymakers and popular among academic institutions. The "regulatory" approach to solving social and economic problems may be seen in other areas such as employment, health, education, and urban policies. Changes during this period were more significant than those of earlier periods to the extent that they indicated the political will to tackle a traditionally neglected problem and insofar as new laws, programs, and norms established the necessary institutional setting for the development of fertility control agencies and service provision programs.

The following major changes were included in the 1973 law:

1. Concerning demographic growth, population "regulation" rather than control was emphasized. This term is a key element in understanding the purpose of the law, which is to adapt population-related activities to match the ultimate objective of the law—the population's welfare. Implicit in the concept of "regulation" is the idea that demographic growth needs to be matched by economic growth, and that reduced fertility is not a policy objective *per se*.

2. The law called for active governmental participation in population programs, which were conceived as a component of the government's social and economic planning responsibilities. In contrast with previous beliefs, the demographic factor was understood to be an inherent component of social and economic development.

3. The two major areas of intervention are population growth and population distribution. The scope of governmental intervention includes (a) concerning population growth, all "proximate determinants" of fertility, mainly family planning programs, and (b) concerning regional distribution of the population, "structural intervening factors" that affect urban and regional development.

Expansion and Increased Efficiency: 1978–94

In 1977 the national family planning program established a demographic target aiming to reach an annual growth rate of 1.0 percent by the year 2000, and corresponding intermediate goals for each administration. The same plan called for the establishment of a National Coordinating Committee of the Family Planning Program, which would be responsible for setting the objectives and goals of the program, and coordinating public and private activities in the contraceptive field. Following the articulation of this aim, the 1978–82 National and Regional Demographic Policy established explicit growth targets, even at the regional level (CONAPO 1978). To achieve the demographic target for the year 2000, the policy proposed to reduce the growth rate from the 3.2 percent observed in 1976 to 1.8 percent by the end of President Lopez Portillo's administration (1982). Accordingly, the policy called for a more organized national family planning program and for the design of a nationwide sex education program.

The 1978–82 National and Regional Demographic Policy strongly emphasized migration and population redistribution. It even included targets and

goals concerning population distribution by the year 2000. Not surprisingly, such goals were soon ignored as more extensive social and economic planning got underway.

By 1980, two years after it was founded, the National Coordinating Committee of the Family Planning Program was dismantled and in its place the General Directorate of Family Planning (DGPF) was created within the Ministry of Health. In 1995, the DGPF was transformed into the current General Directorate of Reproductive Health, with the mandate of integrating all services related to reproductive health into a single regulating office.

From the point of view of policy formulation, it is necessary to stress the demographic policy's target-setting aim. "The first objective," according to the 1978–82 document concerning fertility reduction targets, "is based on the fact that, although the development of Mexico required a large population size during the previous decades, reaching a growth level of around 3.5 percent yearly during the 1960s, our present and future require a slower population growth to make it more adequate to our real prospects of development" (CONAPO 1978: II). The rationale for target-setting was to make consistent demographic and social-economic programs, within a concept of "integrated planning," which was prevalent among planners during the late 1970s.

Moreover, the role of target-setting was to make both planning and intersectoral coordination more efficient. Although we now know that demographic targets can be the source of and inspiration for compulsory and ill-directed programs, at the time targets were regarded as useful instruments for program planning and evaluation. They aroused few objections during the period, either internally or internationally. Furthermore, targets represented parameters for evaluation that were valued by donors and service providers alike.

During the 1984 International Conference on Population, held in Mexico, the official position was that principles contained in the World Population Plan of Action, promulgated in Bucharest in 1974, were still valid, in particular the relationship between population and development. During the 1984 Conference, Mexico stressed that the benefits of reduced population growth should translate into economic development. More importantly for subsequent policy formulations, Mexico proposed: "Demographic targets are not an end in itself. The evaluation of the Plan [of Action], both at the national and international levels, should refer primarily to its qualitative objectives" (CONAPO 1984: 62). Mexico opposed demographic targets to the extent that they failed to consider other "qualitative" factors, such as regional development and improvement of living conditions. Current critics of goal-setting argue that demographic targets ignore women's reproductive health needs and emphasize program needs rather the population's needs. The Mexican argument at the International Conference on Population was different: targets were criticized on the grounds that they ignored positive consequences that slower growth should have on economic and social development. Nonetheless, Mexico still has a demographic goal of reaching a growth rate of 1.75 by the year 2000 and 1.45 by 2005 (CONAPO 1995: 60). Family planning targets and goals of numbers of users,

on the other hand, have had a decreasing significance since 1984 in program evaluation, although they remain in use.

During the Conference, Mexico also stressed the interregional imbalances and inequalities in mortality, fertility, and migration. Mexico called for better founded policies and operational instruments for policy implementation, which may "overcome the purely qualitative level of demographic provisions" (CONAPO 1984). The basic means to achieve this aim, it was argued, were the promotion of demographic research and the establishment of regional State Population Councils.

The Reproductive Health Approach: 1994–Present

The 1995–2000 National Population Policy is a more coherent and comprehensive policy document than any yet elaborated in Mexico. It includes an informed and well-designed analysis of the demographic situation of the country and synthesizes current knowledge on reproductive preferences, contraception, internal migration, population distribution, and family and women's status. It identifies challenges for population policy and, accordingly, sets objectives and strategies.

The major objectives of this policy are as follows:

1. Promote the idea that the demographic transition should be congruent with social and economic development. This objective includes activities to continue mortality and fertility reduction, such as the family planning, health, and information/education/communication (IEC) programs, and other activities aimed at increasing the quality of life and wellbeing of the population.
2. Promote population distribution adequate to the potential of regional development. This includes the creation of rural and urban development policies and activities.
3. Promote integral development of the family—that is, gender equality, responsible parenthood, nonviolence, and equal opportunities for all family members to study and work—through programs oriented toward improving the quality of life and ensuring equal rights and obligations of all family members.
4. Promote women's participation in economic, educational, social, cultural, and political development.
5. Contribute to an improved quality of life and wellbeing of indigenous populations.
6. Promote an awareness of demographic goals and their importance, including (a) an understanding of the relationship between population growth and economic development, (b) an awareness of the burden of large families, especially among the poor, (c) an awareness and knowledge of contraceptive methods, (d) an understanding of the constitutional right to decide one's family size, and (e) an awareness of the constraints that high fertility imposes on women.

Recommendations of the 1994 International Conference on Population and Development were a contributing factor to establishing norms for the provision of reproductive health services. Soon after ICPD, health service institutions,

like the Ministry of Health, changed the names and functions of family planning and maternal and child care offices to include the words "reproductive health." In Mexico ICPD provided a language and justification to develop a more comprehensive approach to women's health needs. It should be acknowledged, however, that in Mexico, in contrast to several countries in Africa and Asia, health services provision is not the exclusive responsibility of one agency or another. The basic health package offered by the Ministry of Health to rural communities, for instance, includes nine programs ranging from vaccinations to infectious diseases, serving women in general, mothers, children, and babies. IMSS and ISSSTE, which are social security institutions, operate under a family-based service provision model, have family clinics that provide required services to all family members, and offer medical consultations to provide comprehensive health services.

But this wide range of services is the ideal. In reality, services are mainly provided on an individual basis, attempting to solve a client's needs during a specific medical consultation. Rarely do service providers inquire about additional needs that women may have, nor do they screen for other services potentially required by clients. A recent study conducted by the INOPAL project of the Population Council evaluated a sample of 500 consultations observed at clinics of the Ministry of Health. In 70 percent of the cases, only the service requested by the client was provided at the time of the consultations.

In the case of Mexico, ICPD provided an international framework to make effective a service provision model that was intended to satisfy health needs of women and families, rather than to offer a specific service, such as family planning. Also, the widening international retreat from programmatic target-setting has decreased the importance of the number of contraceptive users as the main indicator for program performance among governmental institutions. ICPD called on service provision institutions to fulfill their declared aim: to satisfy women's health needs and to provide comprehensive health care. In other words, ICPD did not introduce a new concept in Mexico, but reinforced the idea that such service provision should be a reality and not mere rhetoric.

As a result of several years of groundwork and the favorable climate of opinion created by ICPD, in 1994 the Ministry of Health established medical norms concerning procedures and standards that family planning services should meet nationwide. Similar norms have been developed for pediatric care, maternal and infant care, and other reproductive health services. Although medical norms have long existed, and are part of medical and paramedical training programs, the institutionalization of service provision rules allows for the development of nationally uniform service provision, supervision, monitoring, and training and evaluation practices, and encourages more consistent quality standards. The "Official Mexican Norm of Family Planning Services" aims to "make uniform family planning service provision principles, operation criteria, policies and strategies." As such, family planning is provided within a broader framework of reproductive health and aims to mini-

mize health risks for women, men, and children. Contraceptive services are considered a means to ensure "the right of every individual to decide in a free, responsible and informed manner about the number and spacing of their children, with absolute respect to their dignity" (SSA 1994). The establishment of this norm is relevant for future family planning service provision in the country because of its legal, obligatory framework that public and private service providers should follow.

Of course, the extent to which service providers will follow the prescribed norms and the extent to which the Ministry of Health will enforce its ruling nationwide remain to be seen. Institutional, social, and economic constraints will greatly limit the government's capacity to ensure compliance with the established standards in service provision by the thousands of doctors, nurses, and other paramedical personnel who distribute contraceptive methods or provide family planning services. Certainly, it will take several years to educate service providers about the content and meaning of the prescribed norms, and to make sure that the increasing numbers of service providers are aware of and follow them. Compliance with established rules is contingent not only upon the political will to achieve a minimum standard of quality for reproductive health services, but also upon the development of health services in general.

FACTORS AFFECTING POPULATION POLICY CHANGE

Between the late 1930s and 1950, Mexico saw a period of rapid industrialization and a high demand for labor, which helped to perpetuate a long-standing pronatalist policy that restricted access to contraceptive information, communication, and supplies, stimulated high fertility, and increased the population in vast, already inhabited regions of the country. During the 1960s, Mexico strongly opposed international pressures to reduce population growth. President Echeverría, who eventually enacted the 1973 Population Law, also expressed strong pronatalist views during his administration at the State Department (*Secretaría de Gobernación*) and while running for office. McCoy (1974b) reports that during his campaign, Echeverría reiterated his contention that Mexico needed more people, and "that we need to populate our country." According to contemporary reports, such opinions affected family planning activities and plans importantly. However, without warning, in April 1972 the government announced a comprehensive national family planning program.

It is difficult to attribute this change in the government's stance to any one factor. This section examines the combination of factors that contributed to the government's change of course: (1) structural factors, including social, demographic, and economic variables; (2) internal politics; (3) the role of international agencies; (4) the participation of private institutions, including nongovernmental organizations (NGOs); (5) the role of professionals, scholars, and other elite and pressure groups; (6) the role of the Catholic Church; and (7) the role of socialism.

Structural Factors

Several authors have speculated about the reasons for policy change in Mexico. Alba and Potter (1986) argue that the pronatalist views of administrations from 1940 to 1970 were supported by (1) the comparatively high rate of economic growth, (2) institutional forces such as agrarian reform and the *ejido* system,¹ which enabled Mexico to accommodate a larger population, and (3) rapid urbanization. They contend that the government changed its position because, by the late 1960s, economic growth had slowed considerably and problems related to excessively centralized urban growth began to be felt. This view supports the arguments advanced by two influential economists, Raúl Prebisch and Victor Urquidi, two decades earlier, prior to the establishment of the Mexican population program. In 1970 Prebisch argued against the hypothesis that economic and social development would control the population problem: "I do not believe that the free operation of economic forces will solve these acute problems [referring to the lag between economic and demographic growth], and I have said so for many years. . . . [I]t is necessary to consciously and deliberately act upon demographic forces. . ." (Prebisch 1970: 274).

At the time of the change in Mexico's population policy, during the early 1970s, the relationship between population growth and development was known in the academic literature, through influential studies (see e.g. Coale and Hoover 1958; Kuznets 1960). However, the specific mechanisms through which demographic growth constrains economic development were still under discussion. Scholars were debating the contribution of demographic growth to employment rates, income distribution, savings rates, and industrial production, as well as how these relationships affect social areas such as education, health, and the general wellbeing of the population. In fact, the major objection to population control programs was based on the argument that no direct relationship exists between demographic growth and development per se: some scholars argued that an economic system can accommodate a larger population to the extent that mechanisms of industrial production change accordingly.

Despite those arguments, Mexico's decisionmakers and opinion leaders began to see that rapid population growth is related to economic and social development. To a large extent, the turnabout in the Mexican population policy was a matter of awareness on the part of policymakers about the implications of population growth.

A retrospective view of the documents that informed the semi-public debate on population during the late 1960s and early 1970s reveals a range of attitudes about the need to reduce population growth. For example, the proceedings from a major Latin American conference held in Mexico in 1966, with support from the International Union for the Scientific Study of Population (IUSSP), CELADE, the Economic Commission for Latin America (CEPAL), and El Colegio de México, show a broad range of opinions, both in favor of population control and pronatalist (El Colegio de México 1970).

Many of the arguments presented at this conference, along with other related public and academic forums, contributed to the general change in attitudes about demographic and economic interactions, and set the stage for a positive response to the policy changes to come.

Information concerning the awareness of Mexico's political leaders is scarce. One important study was conducted in the early 1970s by Pablo Pindas, who interviewed key political, economic, and social actors to measure attitudes toward the population problem (Pindas, n.d.). Pindas found a growing concern among leaders about population growth. Only a small group of conservative entrepreneurs objected to family planning on religious grounds. Among the interviewees, positive attitudes toward limiting population growth were associated with political liberalism. Further analyses were conducted at the Mexican Institute of Social Studies (IMES), an NGO, by a group led by Luis Leñero and Enrique Brito (Leñero et al. 1975; Leñero 1979). These studies provided evidence of a widespread acceptance among Mexican leaders of the need to regulate population growth.

A major political actor in the transformation of population policies was Antonio Carrillo Flores, a former holder of the Finance and Foreign Affairs portfolios, who became Secretary General of the 1974 World Population Conference held in Bucharest. Flores, a political insider who had ties to academic and other interest groups, was the architect of the 1973 Population Law. He was an adviser to President Echeverría on population issues and was Mexico's representative at the Bucharest Conference.

Internal Politics

Some analyses of the role of social factors in policy formation are speculative and submit scarce evidence (Marquez 1984). A more systematic approach is presented by McCoy (1974b), who concludes that the turnabout in population policy fits an authoritarian decisionmaking model, to the extent that it was a decision made at the highest levels of the government independent of direct outside or inside pressures.² The policy decision thereby confirmed the role of the president as a patrimonial leader ("a benevolent patron who takes care of his people and who is beyond criticism"), says McCoy, and adjusted the form of the family planning program to fit the revolutionary elite's nationalist and populist ideology—which favored nationalism, welfare for all, government intervention to improve people's living conditions, and egalitarianism. In other words, family planning and contraceptive use came to be accepted by Mexican elites on the grounds that it was a means to achieve the welfare of the people, and not an end in itself.

The Role of International Agencies

Several international agencies were active in Mexico during the 1960s and 1970s. The role of these agencies was to help implement the population policy rather than to change the policy itself. This is important because the timing of

the policy shift coincided with preparations for the 1974 Bucharest Conference. At that point Mexico accepted policy principles endorsed by the United States and other industrialized countries. From the point of view of several Mexican leaders, political and intellectual, such views were imperialistic and undermined the sovereignty of Mexico and other Latin American countries. However, it was the Bucharest Plan of Action that called for "a significant increase of international aid in the field of population, and urge[d] developed countries, and others that may be in the position to help, to increase their assistance to developing countries" (UNFPA 1974: 104).

Aside from the ideological discussion concerning the role of international agencies in the implementation of population policies, the fact is that during the early 1970s Latin America received more international population assistance than other regions of the world, mainly directed to support family planning activities. According to González (1978), the major recipients of international funds in Latin America in 1975 were Colombia (24 percent), Mexico (17 percent), Brazil (15 percent), and Costa Rica (8 percent), which accounted for 61 percent of the total regional population. According to González, the total amount invested in population programs in 1975 was US\$31.5 million (1975 dollars). The main donor in Colombia and Brazil was the International Planned Parenthood Federation (IPPF), with a reported \$3.5 million and \$3.9 million in each country, respectively. Mexico, in contrast, received a reported US\$5.4 million in 1975, with the UNFPA as a major donor (\$2.9 million); the IPPF provided \$1.9 million.

According to McCoy (1974b), private recipients of international funds included the Maternal Health Association, the Foundation for Population Studies, El Colegio de México, the Mexican Institute for Social Studies, and the American-British Hospital. Among public institutions he lists the National Autonomous University, the Women's Hospital, the National Institute of Nutrition, and the Mexican Institute of Social Security.

In Mexico, agencies such as the Ford Foundation and the Rockefeller Foundation, along with the development programs of the United Nations, had traditionally supported projects in agricultural areas, technological innovation, and infrastructure development. However, international financial resources to support the government's family planning initiatives were not substantial enough for institution-building because, after Congress passed the Law on Population in 1973, governmental agencies such as the Ministry of Health and Welfare and the Social Security Institutes, and government-owned enterprises such as PEMEX (the national oil company), moved rapidly to incorporate family planning into their health services with their own resources. International funds proved more important in providing supplies and technical assistance to emerging institutions. In particular, the United States Agency for International Development (USAID) contributed funds to make contraceptives available through private and public sources, starting in the early 1970s. USAID also supported, beginning in the 1960s, pilot tests that led to the establishment of

nationwide family planning programs. In the case of the Ministry of Health, USAID supported a pilot study that contributed to the establishment of a nationwide community-based distribution system to provide services to rural populations (Coverage Extension Strategy, *Estrategia de Extensión de Cobertura*). In the case of the IMSS, USAID in 1976 supported the initiation of a pioneering postpartum program and the introduction of a reproductive risk approach to family planning service provision.

The Ford Foundation played a major role in human resource development and demographic research. A review of its population-related activities from 1952 to 1985 explains that the Foundation was aware that "improvements in contraceptives and family-planning programs could not by themselves reduce excessive rates of population growth . . . and that the success of population programs would depend on millions of individual decisions by men and women making personal choices about sexual activities, contraceptives, and childbearing." The review further states that "[t]hese choices are profoundly influenced by how a family makes a living, by parents' perceptions of their children's chances of survival and their own expectations for old-age security, and especially by such factors as a woman's education and her sense of her own opportunities." The Foundation therefore adjusted its population program in 1980 to take these factors into account (Ford Foundation 1985: 29).

Other international organizations, such as the Latin American Economic Commission and the United Nations, supported research and education institutions dealing with population issues. UNFPA initiated activities in Mexico in 1972, with the government's agreement, to support the Foundation for Population Studies (*Fundación para el Estudio de la Población*, FEPAC), the IPPF affiliate in Mexico, in providing family planning services. In 1975, the Mexican government and UNFPA agreed on an expanded program of medical services for maternal/child health (MCH) and family planning, and scheduled the project to run for five years (mid-1974 to mid-1979). Executed by the Pan American Health Organization in cooperation with the Ministry of Public Health and Welfare of the Government of Mexico, the program provided contraceptive and MCH services through 1,500 health centers around the country in 1975, with a planned, gradual expansion into rural areas (UNFPA 1990).

By 1979, the UNFPA assistance program was emphasizing the extension of services into marginal urban and rural areas; strengthening the government's implementation, evaluation, and supervisory capacity at the central, state, and local levels; training, including training of community-level personnel; and assistance in the development of an IEC component. In 1988, a UNFPA directory, *Inventory of Population Projects in Developing Countries Around the World*, listed more than 25 projects in Mexico directly under UNFPA support. Other active international institutions in the population field in Mexico included the World Bank, the World Health Organization, and bilateral agreements of the Japan International Co-operation Agency, the British Overseas Development Administration, and the Canadian International Development Agency. Nongovernmental

organizations included the Association for Voluntary Surgical Contraception (AVSC), the Center for Population Options, the Centre for Development and Population Activities (CEDPA), Development Associates, Family Health International, Family Planning International Assistance, the Institute for International Studies in Natural Family Planning, the International Development Research Centre (IDRC), the International Planned Parenthood Federation, International Projects Assistance Services, John Snow, the Pathfinder Fund, the Population Council, the Program for Appropriate Technology in Health (PATH), the Rockefeller Foundation, Save the Children, and the University of Chicago Population Center.

The Role of Private Organizations

During the early 1960s, only one private family planning organization existed in Mexico—the Foundation for Population Studies, later to become the Mexican Family Planning Foundation (*Fundación Mexicana de Planificación Familiar*, MEXFAM), which is currently the IPPF affiliate in Mexico. To increase the role of the private family planning sector in Mexico and to organize the many small organizations providing health services to marginal populations, USAID in 1973 initiated support of the Mexican Federation of Family Planning Associations (FEMAP), an umbrella organization that included six affiliates in the late 1970s and currently incorporates more than 40 organizations nationwide. Numerous FEMAP affiliates had been developed by spouses of prominent entrepreneurs who direct philanthropic efforts to family planning, health, and community development activities.

Merrick (1989) suggests that “If donors’ expectations were that these efforts would yield a change in official policy and publicly supported program, the overt impact of these efforts was marginal.” Directors of the private family planning organizations disagree. M. Alfonso Lopez Juárez, the current director of MEXFAM, says, “The major impact at that time was on public opinion. FEPAC represented a small, liberal group defending a basic woman’s right, but had nationwide support among the population and among some political groups” (personal conversation).

Merrick continues, “If the efforts of the population community had any influence on the policy turnabout that eventually occurred, it was more likely to have been channeled through key individuals in these institutions who had connections at the top of the PRI [*Partido Revolucionario Institucional*, Institutional Revolutionary Party] political apparatus by virtue of personal political ties or elite status” (1989: 13). Along these same lines, Nagel (1978) noted that President Echeverría’s wife, who arranged a series of family planning lectures sponsored by the National Institute for the Protection of Children, may have played a key role in changing his mind on this issue. Unlike Merrick, McCoy (1974b) stresses the deterioration of the country’s economic and political situation and the rate of population growth as contributing to the policy change.

The Role of Intellectuals and Professional Groups

In Mexico, intellectuals and scholars play an important role in policy change and development (Marquez 1984). Clearly, prominent scholars issued warnings about rapid population growth several years before it became fashionable to do so. The first academic center for demographic studies (*Centro de Estudios Económicos y Demográficos, El Colegio de México*) was established in 1964, and by 1966 it conducted the first Latin American Regional Conference on Population, mentioned previously. Among the recommendations submitted at this conference was

. . . the need to call attention in public and private organizations, national and international, to enlarge efforts to increase objective knowledge of the relationship between population and development. . . . Fertility control, to benefit families affected by the demographic disequilibrium, should be provided as a public service by all governments, regardless of the development strategy pursued. (Lerner 1970: 443)

Opinions and recommendations of prominent intellectuals were highly influential in shaping the 1973 Population Law. Academic and intellectual groups wielded such influence for at least two reasons: (1) intellectuals in Mexico traditionally have had a high standing and reputation and (2) the academic and public sectors are highly conversant with each other. In Mexico intellectuals have a great deal of public trust, not infrequently in areas well beyond their expertise, and they expressed "informed" opinions concerning the nature of an "appropriate" population policy.

Mexico's intellectuals also played an important role in influencing ideas about demographic issues in their capacity as public officials, consultants, and advisers to high-level government officials. Likewise, prominent officials may teach courses or coordinate research while in office, or else return to the university while inactive in public life, enabling the cross-fertilization of ideas between the academic and public spheres. Not infrequently, researchers direct their efforts to satisfying public-sector requirements. In the case of demographic research, this translates into academic projects to study levels and trends in fertility and mortality. On the other hand, public-sector programs, plans, and evaluations draw heavily from academic projects. As of 1994 an inventory lists nearly 200 ongoing research projects in 34 research centers in the country (Benítez and Ramírez 1994).³

The Role of the Church

The Catholic Church proved uninfluential in the turnabout of the Mexican population policy. Although 95 percent of the population was Catholic at the time of the policy turnabout and the church expressed strong objections to a nationwide contraceptive distribution program, the point of view of the church is conspicuously lacking in the population debate in the country. Even the Vatican's decree that men and women using any "unnatural" contraceptive

method would be violating church rule was apparently ignored by the increasing number of women practicing contraception.

The lack of influence of the Vatican and the national ecclesiastical hierarchy is attributable to two factors: (1) in contrast to most Latin American countries, in Mexico since 1880 a separation has existed between the state and the church; (2) until 1992 priests were entitled to express their opinions only as common citizens and not in public forums as official religious representatives.

Thus, the Mexican government was able to discuss and pass the 1973 law without considering religious matters. The politically prudent Mexican church refrained from launching an organized opposition to family planning and concentrated on actively opposing, within the church itself, contraceptive use. This opposition, however, had little impact on individual fertility behavior.

An additional factor that contributed to the lack of intervention by the church and the turnabout of Mexican demographic policies is that abortion issues were put aside in public discussion. Legalization of abortion was never an issue during the phase of policy formulation. On the contrary, contraceptive use was argued to be a means of avoiding and reducing reliance on induced abortion. By avoiding a controversy over abortion and dissociating contraceptive use from a tolerance for abortion, the Mexican government avoided a more direct confrontation with the church.

The Role of Socialism

Finally, one factor that has not been analyzed adequately among the forces shaping President Echeverría's change of mind is his populist orientation and the influence that the socialist models exercised on his thinking. One may speculate that during the first years of his administration, President Echeverría learned that population control was prevalent within socialist countries, from the former Soviet Union to Cuba. Furthermore, population control increased the prospect that centralized planning would be successful. It is possible that a major factor affecting the Mexican turnabout was the model provided not by Western industrialized countries but by the former Soviet bloc, China, and Cuba.

POLICY IMPLEMENTATION

The Role of the National Population Council

Although the 1973 Population Law describes demographic variables as being influential in the social and economic development of the country, it establishes that the entity responsible for implementing population policies is the *Secretaría de Gobernación*, the equivalent of the State Department in the United States. Apparently, this is justified on the grounds that population policies, including internal and international migration, should be part of the "general State policy" and are matters of national security.

The main implementing agency responsible for demographic planning in Mexico is the National Population Council (*Consejo Nacional de Población*,

CONAPO), which coordinates all governmental activities related to population issues. At its inception in 1974, CONAPO included the Education, Health, and Treasury departments and also the Ministries of Foreign Relations and Agrarian Affairs, to deal with migration issues. In 1992, an addendum to the law incorporated the country's major health service providers into CONAPO, to further coordinate family planning and reproductive health services.

Demographic planning at the regional level differs from national planning. To enhance the planning capacity of local governments, CONAPO initiated in 1974 a program directed at strengthening the planning abilities of state-level governments. The pilot program resulted in agreements between CONAPO and 19 states, which called for the establishment of demographic research and planning units in each state. In 1983, with the establishment of a National Planning System intended to coordinate all governmental planning activities, CONAPO created the Regional Population Councils (*Consejos Estatales de Población*, COESPOS), which are dependent upon the state government but receive programmatic guidelines from CONAPO. Some of these regional COESPOS offices have evolved into individual agencies that can function independently. But more frequently they have failed to play their anticipated role—which was to function independently of CONAPO and to become state-level advisers to governors on population issues.

Population Education and Communication

The Mexican population programs have emphasized education as a major means to develop a "demographic culture" that, in turn, should enable couples and individuals to make conscious decisions about reproductive matters and hence to improve their quality of life. Public and private institutions have devoted vast resources to educational programs, including mass media, textbooks, and other printed materials.

Mass information and communication activities started in Mexico as early as 1974 with a nationwide Program on Public Information and Orientation, which aimed to "promote public awareness concerning demographic problems" and to promote the recently initiated governmental actions in the area. The initial information activities also included a communication campaign aimed at increasing public awareness about population issues and was conducted in three phases, each emphasizing a different topic: (1) "Let's be less . . . to live better"; (2) the effects of family planning on health, education, economic wellbeing, and family life; and (3) "Small families live better."

In addition to communication campaigns, the educational sector incorporated in the official primary school textbooks information on human reproduction and sexual hygiene. These texts included chapters on the family, the community, and health and environmental issues. Textbooks directed at post-primary students also included population topics.

The Mexican government established a National Sex Education Program in 1979, which included a strategy to provide sex education through the educa-

tion sector, the health sector, and private community organizations. The sex education program relied on trained counselors to provide information to a wide range of groups. In 1983, the National Program on Population Education increased the scope of sex education to include population issues.

Sex education has not been included in the curricula of Mexican public schools, despite the fact that family planning has been one of the nation's priorities for the last 15 years and that during this period adolescent fertility has increased its contribution to the total fertility rate. This lapse is the result of a cautious attitude on the part of the Mexican government toward the opinion of some parents' associations, rather than a lack of information regarding the demand for or the benefits of sex education in schools. A national survey conducted by CONAPO among high school students found that students felt their information about sexuality and contraception was inadequate or incomplete, and nearly all the students felt that this information should be included in the school curriculum (CONAPO 1988). A survey conducted by the Mexican Institute of Family Studies (IMIFAP) tested a comprehensive sex education course entitled *Planeando tu vida* ("Planning Your Life") in public schools in Mexico. The study found that the course improved adolescents' knowledge about sexuality, pregnancy, and contraception, and that among those teens who took the course before becoming sexually active, the probability of using contraceptives increased significantly (Pick de Weiss et al. 1992).

Sex education activities were also included in the National Population Education Program for the period 1983–88. During this period, sex education was implemented as part of a more general approach to population education. The objective of this program was to inform the public to the maximum extent possible, with the expectation that they would then make more informed decisions about family size, sexual activity, and reproductive behavior.

The education strategy of this program was based on four components:

1. the provision of information concerning population size, structure, and distribution problems, causes and consequences of population growth, and relevant demographic information, including general reference information on population education and research;
2. school education, which included population topics in the curricula of primary, post-primary, and higher-level institutions;
3. extension and training, which provided materials and training for adult education, social services, industries, and the like, and which resulted in the development of high-quality printed and audiovisual material;
4. population communication, mainly through the press, radio, television, and films (most salient among the messages produced under this program were the television advertisements and the *democapsulas*—short messages that presented demographic information and alluded to population problems).

IEC activities in Mexico have increased in scope from sex education and family planning to a wider approach including population issues at large, the environment, reproductive health, urban growth and regional development,

gender inequality, and the family. After 20 years of continuous activities, IEC efforts in Mexico may be considered comparable with those in the most advanced countries in the industrialized world; such efforts rely on the active participation of several institutions related to population and development, environment, the family, sex education, and other areas.

Family Planning

The 1978–82 National and Regional Demographic Policy established specific goals and targets for a demographic transition. These targets enabled incumbent institutions to define expected fertility rates and contraceptive prevalence goals. Prevalence targets were the core element in the National Family Planning Program, which was part of the National and Regional Demographic Policy document. According to this document, family planning activities throughout the country were to be conducted by an Interinstitutional Coordinating Committee of the Family Planning Program that includes representatives of all family planning service provision institutions. These are the IMSS, the ISSSTE, and the Ministry of Health (*Secretaría de Salud*, SSA).

Between 1982 and 1989, family planning policies in Mexico were reinforced in normative and operational terms. From a normative perspective, family planning was incorporated as a priority within the National Development Plan and as an explicit component of social policies concerning health. Also, family planning was incorporated as a priority of the General Law of Health in 1984 and as a strategic resource both in the National Program on Population and the National Program on Health (Sandoval 1994).

From an operational perspective, the priorities of the Interinstitutional Coordinating Committee of the Family Planning Program, which regulates all governmental activities related to contraception, were restated to include the following:

1. Determine targets and strategies for agencies and offices pertaining to the health sector.
2. Extend coverage to rural populations.
3. Increase male participation in the program.
4. Provide sex education and family planning services to young adults.
5. Institutionalize and standardize training and supervision procedures for health workers.

To provide a general framework for state-level programs, CONAPO and the corresponding regional COESPOS offices have conducted, since 1984, 32 sociodemographic studies, one for each state in the country. These studies describe characteristics of contraceptive users, health conditions of local populations, demographic trends, and prevalent socioeconomic conditions. In 1985 a new procedure for planning and resource allocation was implemented, to assign budgeting responsibilities to state governments. Within this decentralized planning framework, the central administration is responsible for monitoring and auditing activities, rather than direct assignment of resources, as was the

case prior to 1985. Activities of the Ministry of Health and the Mexican Institute of Social Security are described below.

Ministry of Health. The Coverage Extension Strategy (CES) of the Ministry of Health aims to provide health services and primary attention to underserved rural populations in communities with fewer than 2,500 inhabitants. Primary attention includes pre- and postnatal care, family planning, infant care, vaccinations, immunizations, and related services. The CES initiated activities in 1986 and, according to the 1989 Annual Report, the strategy covered 12,111 rural communities including 11 percent of the national population.

The CES is organized through modules (territorial units). Each module consists of approximately ten health auxiliaries, who are trained and monitored by supervisors of health auxiliaries. Supervisors, in turn, are monitored by a jurisdictional medical coordinator. Typically, each health jurisdiction (an officially designated geographical area for organizing and administering services provided by hospitals, health centers, and health posts) has one coordinator, four supervisors, and 40 health auxiliaries.

Health auxiliaries are voluntary health workers, in some instances elected by the community, who receive a nominal monthly compensation of 50 Mexican pesos (US\$17) for services rendered. Responsibilities include the provision of basic health services and the distribution of contraceptives (pills, condoms, and injectables) and other products, such as oral rehydration supplies, antihistamines, and analgesics. In addition, health auxiliaries are responsible for promoting the family planning program and motivating rural women of reproductive age to use contraceptive methods, which are distributed at no cost to consumers. Available statistics show that health auxiliaries provided services to approximately 87,090 new users and 239,509 active users during 1989 in the 12,111 communities reached by the CES. Health auxiliaries provide services in posts called "Health Houses," which are facilities provided by communities and, in some instances, by the health auxiliaries themselves.

Supervisors of health auxiliaries typically are registered nurses who are responsible for recruiting health auxiliaries, promoting and distributing contraceptives and other products to them, training and monitoring, and contributing to administrative tasks. Supervisors are located in "health centers" (or community centers) that offer the services of a physician, a nurse, and a health promoter (a community worker with basic health training who provides information and supplies for primary care to rural populations). According to CES norms, supervisors of health auxiliaries should visit each community at least once a month. Each supervisor is responsible for monitoring ten health auxiliaries in approximately ten communities.

Jurisdictional medical coordinators are physicians who supervise family planning activities within a health jurisdiction as defined by the Ministry of Health. Currently the country is divided into 268 health jurisdictions. The number of jurisdictions within each state varies according to local conditions and the size of the state. Each jurisdictional medical coordinator is responsible for supervising approximately four supervisors of health auxiliaries.

According to the CES, the jurisdictional medical coordinator in each state should meet monthly in the state capital to discuss progress and problems in each jurisdiction and determine the extent to which targets for new and current users have been achieved. New strategies and priorities may be set in these meetings.

To support the decentralization strategy within the Ministry of Health, annual National Planning and Evaluation Workshops are conducted. These meetings are attended by family planning officers from both the central and state levels. The National Workshops aim to assess progress, problems, and strategies for local programs. Logistics, training, supervision, and promotion activities for the forthcoming year are scheduled.

Mexican Institute of Social Security. A major actor in public family planning service provision is the *Instituto Mexicano del Seguro Social*, which started systematic family planning activities in 1977 and, since the early 1980s, has been responsible for about 50 percent of contraceptive coverage nationwide. The IMSS family planning program is mainly directed toward urban working populations; however, it has also provided services to some rural populations, through local hospitals, clinics, and health centers.

Since 1981, IMSS has established referral networks among rural health units and midwives (*parteras empíricas*) working in communities. The community-based midwife program continues as a model for several Latin American countries. Under the IMSS program, midwives provide up to 30 percent of maternal and child health care and family planning services offered by the institution.

THE DEMOGRAPHIC IMPACT OF MEXICO'S POPULATION POLICY

Fertility Patterns and Trends

Between 1960 and 1995 the total fertility rate (TFR) in Mexico declined from 7.0 to 2.7 children per woman. The age-specific fertility rates (ASFR) and the TFR for various years are shown in Table 5.1. During the late 1960s and early 1970s, prior to the initiation of policy changes and the establishment of the national family planning program, the TFR dropped slowly at an average rate of 2.4 percent per year (a decrease of 0.16 children per woman yearly). From 1975 to 1981, the period of consolidation of the national program, the rate of fertility decline increased to 4.0 percent per year, i.e., 0.23 children per woman per year. Since 1981, fertility reduction has continued at an average pace of 2.3 percent per year or about 0.10 children per woman per year. This analysis of available surveys shows that the major reduction in fertility was achieved during the six-year period from 1975 to 1981, and the 11 years from 1981 to 1992 show a moderate rate of reduction.

Available demographic survey results show that fertility-related age patterns have changed in absolute and relative terms over the 20-year period since the initiation of the new Population Law. The greatest reduction in fertility occurred among women beyond 30 years of age. The fertility of women younger

Table 5.1 Age-specific fertility rates: Mexico 1968–92

Age group	Fertility rates (births per 1,000 women)					Percent decline	
	1968	1975	1981	1986	1992	1968–75	1975–92
15–19	125	105	106	80	82	16	22
20–24	311	276	203	198	174	11	39
25–29	331	269	211	192	166	19	38
30–34	275	231	172	147	116	16	50
35–39	207	173	122	97	74	16	57
40–44	104	74	43	37	21	29	72
Total	6,765	5,640	4,285	3,755	3,200	17	43

Sources: Welti 1988; Paz 1993; CONAPO 1996.

than age 30 also declined substantially between 1975 and 1992. Other characteristics of the age pattern of fertility include an increase in the age at childbirth, and an increasing number of women spacing their pregnancies or limiting childbirth. As observed from a demographic perspective in 1995, the major problems in the reproductive patterns of the Mexican population are (1) early initiation of reproduction, (2) short birth intervals, and (3) wide urban–rural differentials in fertility patterns.

Early initiation of reproduction is demonstrated by the large number of women giving birth prior to 18 years of age. According to the 1990 Census, more than 250,000 women had between one and four children prior to age 18, and a total of 719,000 children were born to these young mothers. In total, 17 percent of the expected number of births per year occur among women under 20 years of age (CONAPO 1996). The demographic impact of early initiation of reproductive life in Mexico is confirmed by an estimate of the cumulative fertility of women who had a first birth prior to age 18, compared with women who had their first birth between 18 and 22 years of age, and those who became first-time mothers after age 22. The cumulative fertility 12 years later among women who gave birth before age 18 (that is, when these women are 30 years old) is estimated to be 4.8 children; the comparable figures for women who had their first birth between the ages of 18 and 22 and those who became mothers after age 22 are 4.2 and 3.2 children, respectively.

The problem of early initiation of fertility is, in turn, related to child spacing, from marriage to the first birth and between subsequent births. The average age at marriage in Mexico is 19.5 years among women, with wide differences between rural and urban areas. The time trend indicates that older cohorts married at even younger ages than recent cohorts. According to a demographic survey conducted in 1992, 18.7 percent of women born during 1940–49 married before age 16, and 57.9 percent married before 20 years of age. Among more recent cohorts, the corresponding fractions are 10 and 39.2 percent, respectively. The most salient factors affecting age at marriage are place of residence and education (CONAPO 1996).

Demographic surveys (INEGI 1992) show that 54 percent of women give birth within the first year after marriage, and this pattern has remained constant among different birth cohorts. The fraction of premarital births is 6.5 percent among all age groups; however, the proportion of premarital conceptions—that is, births that occur within seven months after marriage—has increased from 12.5 percent among older birth cohorts to 18.0 percent among younger women.

Early marriage and early initiation of childbearing in Mexico have economic, social, and cultural causes. From an economic point of view it may be argued that the value of children remains high in Mexican society, where traditional and modern systems coexist. Among rural populations in particular, the income-generating capacity of children and expectations concerning intergenerational capital flows provide incentives to higher fertility and lower age at marriage and childbirth. From a cultural perspective, it has been argued that early initiation of childbearing is important to ensure the fecundability of women, which is greatly valued because of the high economic value of children among rural populations.

Notwithstanding these traditional supports for high fertility, the economic value of children tends to decrease over time in modern economies, where children are not economically active or economically productive. Children's economic value also tends to decrease in urban areas, where they cannot be employed in agricultural work or contribute to the family economy. Finally, in modern societies the value of children as a source of income when their parents grow old tends to be lower than in more traditional societies.

Indeed, demographic change has not been homogeneous in Mexico. A demographic survey conducted in 1992 (INEGI 1992) shows that rural-urban differentials in fertility rates are high. Rural fertility is more than two times that of urban areas. For example, the total fertility rate in Chiapas, Oaxaca, and Guerrero (mainly rural states) is between 4.5 and 4.6 births per woman, compared with a TFR in Mexico City of 2.2. Statistical analysis shows that the rural-urban fertility gap has narrowed during the last 20 years. These trends are further confirmed by a survey conducted in 1995 (CONAPO 1996), which shows a significant difference between the lowest fertility rate in the country (2.2 children per woman in the Federal District) and the highest fertility levels (above 3.0 children per woman), which are observed in the poorest states, among them Chiapas, Puebla, Oaxaca, Zacatecas, and Querétaro.

Several studies have demonstrated the diffusion of demographic change that originated in larger cities and continued to smaller urban centers and rural areas, clearly following the distribution lines of available health services. Also, fertility decline follows social and economic lines, starting with the better-off and educated groups, and spreading to classes with lower educational attainment. Empirical analyses show that fertility decline is positively correlated with socioeconomic development at the regional level (CONAPO 1995); however, with the available information it is not possible to determine the rela-

tive contributions of socioeconomic development and availability of health/family planning services to fertility decline.

Demographic analyses show that the contribution of natural growth (births minus deaths in a population during a given period) to total growth (natural growth plus immigration minus outmigration) diminishes over time. Estimations made in 1992–93 indicate that a total growth rate of 1.9 percent was the result of a 2.2 percent natural growth rate and a –0.3 percent rate of net migration. While the contribution of natural growth has declined, the contribution of net migration has increased. This observation has important policy implications:

1. Although the population policy has had a demonstrable impact, it is necessary to reinforce this program to further reduce growth. This point is important because during the 1970s and 1980s several authors argued that a reduction of growth rates could only be achieved through social and economic development. The best contraceptive, they argued, is development. Current trends demonstrate that population growth may decline prior to achieving development.
2. The country shows net outmigration (–0.3 percent). This is a significant figure that suggests the need to generate more jobs and improve living conditions to retain potential outmigrants. Policies should focus on development strategies in states and regions where outmigration flows originate.

Contraceptive Use and Fertility Preferences

From 1976 to 1987, average desired family size in Mexico decreased by 1.2 children—from 4.5 to 3.3. In 1976 women older than 35 years of age wanted more than five children in their families. A decade later, only women older than 44 years said they wanted four children on average, while the younger age groups declared preferences near three children (CONAPO 1996).

The average desired family size shows wide variations among residence, educational, and labor force participation groups. By 1987, rural women declared a desired family size of 4.3, almost twice the average for women living in metropolitan areas, where the average desired family size was 2.5 children. Such differentials are also observed among educational groups: while women with no formal education declared a desired family size of 4.9, women with more than a primary education wanted an average of 2.5 children.

As shown in Table 5.2 contraceptive prevalence increased from 30 percent of married women in 1976 to 48 percent in 1982 and 63 percent in 1992. However, contraceptive prevalence varies widely among regions and among educational and residence groups (Dirección General de Planificación Familiar 1988).

Women with no formal education currently have an average prevalence rate of 38 percent, compared with 74 percent among women who have a post-primary school education. Similarly, the contraceptive prevalence rate in rural areas is 44 percent, compared with 70 percent in urban areas. In spite of recent advances of the national family planning program in rural areas, urban women are 60 percent more likely to practice contraception than comparable rural women.

Table 5.2 Percent distribution of married women using a contraceptive method, by type of method and age group: Mexico 1976–92

Type of method	1976	1979	1982	1987	1992
Modern methods	23.1	32.0	41.5	44.8	55.0
Any method	30.2	37.8	47.7	52.7	63.1
Age group	All methods				
15–19	14.2	19.2	20.8	30.2	36.4
20–24	26.7	37.4	45.7	46.9	55.4
25–29	38.6	44.5	56.5	54.0	65.7
30–34	38.0	49.6	59.8	62.3	70.1
35–39	37.9	42.8	57.6	61.3	72.6
40–44	25.1	33.3	42.9	60.2	67.4
45–49	11.8	16.3	22.1	34.2	50.5

Source: CONAPO 1994: Table 1, p. 3.

There are wide interregional variations among states. The lowest prevalence rates range between 46 and 50 percent in states with a high concentration of poverty, like Oaxaca, Guerrero, Puebla, Chiapas, and Querétaro. The highest prevalence rates are between 70 and 77 percent, mainly in the central and northern states (Sonora, Sinaloa, Chihuahua, Coahuila, Baja [California], Nuevo León, Mexico City, and the Federal District). In fact, the country can be divided into three main regions: the northern region, with a high prevalence rate, above 65 percent in most cases; the central region, which includes Mexico City and surrounding areas; and the southern region, with low prevalence rates and pervasive poverty. Regional differences in contraceptive use rates are also correlated with aggregate and individual educational levels and participation of women in the labor force. Another factor that has proven significant is the distance to urban centers: contraceptive use becomes more prevalent as one gets closer to an urban center. This finding is relevant from a policy perspective because it indicates the need to strengthen rural services.

Contraceptive knowledge in the country is pervasive. However, according to demographic survey evidence (INEGI 1992), 26 percent of rural women fail to use contraceptives because of a lack of knowledge about various options or because of an inadequate source of supply.

Demographic surveys show that the method mix has changed substantially since 1976. At the onset of the population program, 36 percent of women using contraceptives relied on pills; by 1992 that proportion had declined to 15 percent (see Table 5.3). The fraction of women undergoing a tubal ligation increased notably, from 9 percent in 1976 to 43 percent in 1992. Users of IUDs declined slightly from an estimated 19 percent in 1976 to 18 percent in 1992. Also, the number of users of traditional methods (rhythm, withdrawal, and abstinence) was halved, from 23 to 12 percent. To summarize, the method mix has changed over the last 20 years from pill- and IUD-based to a program based on female sterilization. The main reason for the shift to sterilization is that women practice contraception mainly to limit childbirths rather than to

Table 5.3 Percent distribution of contraceptive users by method chosen: Mexico 1976–92

Contraceptive method	1976	1979	1982	1987	1992
Oral	35.9	33.0	29.7	18.2	15.3
IUD	18.7	16.1	13.8	19.4	17.7
Tubal ligation	8.9	23.5	28.1	36.2	43.3
Vasectomy	0.6	0.6	0.7	1.5	1.4
Injectables	5.6	6.7	10.6	5.3	5.1
Condoms and spermicides	7.0	5.0	4.1	4.7	5.0
Traditional methods	23.3	15.1	13.0	14.7	12.2
Total	100.0	100.0	100.0	100.0	100.0

Source: CONAPO 1994: Table 1, p. 3.

space children. They decide to get sterilized once they have had two or three children, with little spacing between births.

Concerning the contraceptive method mix, the National Population Program (1995–2000) correctly states:

It is clear that family planning services have been oriented primarily (to a large extent through the postpartum programs) to provision of [female] VSC [voluntary surgical contraception,] which is a method directed to family size limitation. A major demographic and health burden is that service is provided to couples that have a large number of children. Available data show that between 1985 and 1992 more than 50 percent of VSC users had four or more children at the moment of acceptance. This shows that the benefits implied by the use of the method are reduced by the fact that an important fraction of couples decide to limit their number of children relatively late. (CONAPO 1995: 24)

Table 5.4 shows the market share of each family planning service provider. The major providers in the country are governmental sources, including the Mexican Institute of Social Security and the Ministry of Health, which together serve approximately 66 percent of current users. Among governmental sources, the IMSS has a 75 percent share of current users. Approximately 65 percent of contraceptive clients at both the IMSS and ISSSTE have undergone voluntary surgical contraception, compared with 41 percent among SSA clients. The Ministry of Health is an important provider of oral contraceptive methods, mainly due to the community-based distribution of pills among rural populations.

The second major provider of contraceptive methods after the governmental sources are pharmacies, which are also the major source of methods for first-time users. Sixty percent of pill users and 80 percent of users of injectables and other local methods (that is, vaginal methods such as spermicides and condoms) obtain their contraceptives from pharmacies. These methods are chosen mainly by young, first-time users. This is important because it implies that a large share of young couples are obtaining methods without proper counseling and information, which is crucial for the selection of an appropriate method, and its use including continuity and effectiveness.

Table 5.4 Percent distribution of contraceptive users by source of method: Mexico 1979–92

Institution and type of method	1979	1987	1992
IMSS (Mexican Institute of Social Security)			
Orals	24.3	5.5	6.1
IUD	27.2	27.1	27.5
Surgical	46.5	65.8	64.6
Injectables and local	2.0	1.6	1.8
Total	100.0	100.0	100.0
ISSSTE (Institute of Social Security for Federal Employees)			
Orals	22.1	6.0	8.8
IUD	19.0	22.6	19.8
Surgical	55.3	66.8	68.3
Injectables and local	3.6	4.6	3.1
Total	100.0	100.0	100.0
SSA (Ministry of Health)			
Orals	42.1	26.2	22.6
IUD	36.7	35.4	25.3
Surgical	18.0	29.0	41.1
Injectables and local	3.2	9.3	11.0
Total	100.0	100.0	100.0

Source: CONAPO 1994: Table 13, p. 19.

Indicators of continuity of use have also changed since the inception of the 1973 Population Law. The method-specific continuation rates at the end of 12 months of use have decreased from 58 percent in 1973–79 to 49 percent in 1987–92 among pill users, and from 82 percent to 69 percent among IUD users. In the case of oral contraceptives the main causes of discontinuation are method failure and side effects. Side effects are also an important factor for IUD abandonment. In both cases, the quality and type of information received are important factors affecting continuity.

The total demand for contraceptive methods has increased to 78 percent of married women of reproductive age, expressing a desire to limit or postpone childbearing. This includes the 53 percent of women who have actually been provided with contraceptive methods: 39 percent using contraceptives to limit fertility and 14 percent to space births. Unmet need thus accounts for 25 percent of married women of reproductive age, among whom 16 percent wish to terminate childbearing and 9 percent would like to postpone births.

The Mexican fertility policy lacks an instrument to direct service provision more efficiently, beyond the use of global targets of contraceptive use. One of the main challenges for the Mexican family planning program is to satisfy unmet need, which is mainly concentrated in the rural areas among women with low literacy rates. In urban areas, education is the main factor determining unmet need. On this basis, the 1995–2000 National Population Program concludes: “The level that unmet need has reached shows deficiencies in access and quality of family planning services. Therefore, it is essential to strengthen

actions to make services available to all segments and groups of the population, so that couples may achieve their reproductive rights established in the fourth article of our Constitution."

According to the National Population Plan of 1995, the priority for the rest of the twentieth century is to delay the first pregnancy among Mexican couples. Only 21 percent of childless couples practice contraception to postpone first births, including only 6 percent of recently married childless couples in rural areas (CONAPO 1995). Another priority for the Program is to address the need of adolescents 10 to 19 years of age, who are at various times exposed to the risk of pregnancies and sexually transmitted diseases. This segment represents about one-fourth of the total population, and they require information and education services concerning sexuality and reproductive health. Every year there are approximately 500,000 pregnancies among adolescents 15–19 years of age, representing one-sixth of all births that occur every year. A third priority is to promote the participation of men in family planning. Mexican men tend to regard fertility matters as an exclusively female concern, or to oppose contraceptive use. Vasectomy is the least used contraceptive method in Mexico—1.4 percent in 1992, compared with 12 percent in 1988 in the United States, and 14 percent in 1983 in the United Kingdom (Ross, Mauldin, and Miller 1993: 44–46).

Urban and Regional Policies

Urban and regional policies are far less developed in Mexico than population growth policies, as evidenced by the fact that regional inequalities and the widening gap between central cities and smaller urban centers perpetuate the historical trends observed since the early 1960s.

Demographic analysis demonstrates that urban and rural growth are closely related and, as a consequence, it is possible to estimate the balance of growth and size within both populations (Ledent 1982; Rogers 1982). These studies demonstrate that urban populations grow over long periods through immigration flows that enable cities to expand. However, contrary to current beliefs, immigration declines as a contributing factor of demographic growth throughout the process of urban development.

The general conclusion of demographic studies on rural–urban migration is that, during an urban transition, populations grow initially as a consequence of urban immigration; then, as urban settlements consolidate, the main growth source becomes the natural growth rate and the relative contribution of migration decreases rapidly.

The important question from a policy point of view is whether the above trends may be reversed or counterbalanced through social and economic instruments. The apparent universality of these patterns makes it difficult to believe that national policies can significantly modify expected trends. In particular, the demographic argument seriously challenges the policy premise that urban growth can be regulated through disincentives to migration without a significant reduction in fertility levels.

DISCUSSION

Population control policies in Mexico since the 1960s have reduced barriers and obstacles that had made contraceptives accessible only to the middle and upper classes. Actual intervention made contraceptives available to large shares of the population.

As Urquidi (1989) noted several years ago, the population control effort in Mexico started at least ten years late. During the 1960s leaders and major actors were largely unaware of population issues and their relationship to economic and social dynamics. Only a few demographers and physicians were active in the field and they were largely ignored by politicians and program planners. By the early 1970s, when the population policy was enacted, the cumulative population growth had achieved a momentum that the Mexican economy was not ready to meet.

Currently, Mexico expects to reach replacement-level fertility (the level necessary for the population to replace itself and, eventually, to stop increasing) by the year 2005. The main instrument for achieving this aim continues to be fertility control. The total fertility rate, which was 7.0 children per woman in 1960, is currently at 40 percent of its initial level. Programs are expected to further reduce fertility to 2.4 children by the year 2000 and to 2.1 by 2005. This goal requires the contraceptive prevalence rate to increase to 70 percent by the year 2000 and to 73.5 percent by the year 2005, which implies a total coverage of 13.8 million contraceptive users by 2005.

The major challenge to the current family planning and reproductive health program in Mexico is to reduce interregional inequalities in provision of education, health, and family planning services. Another challenge is to develop the human and material resources to enable decentralized states to implement development strategies that enable them to manage, evaluate, plan, and direct services.

The document titled *Analysis of Results of the Interinstitutional Family Planning Program*, which reports on the annual progress of the program, suggests the following concerning the need to increase the effort of decentralization:

It is necessary to consolidate the leadership of the program; this is to say, that state officers undertake a more active role, both in planning and monitoring of activities; coordination amongst sectors and institutions should have an operative approach at the state level. . . . [State officials should ensure] close surveillance of development and accomplishment of planned targets, as provision of required resources and definition of specific strategies for each segment of the population. (SSA 1990: 20)

The report states that it is necessary "to reinforce activities in rural areas, because no significant advances had been achieved in these regions. . . . Therefore, it is necessary to improve accessibility to the program, as well as the continuity of contraceptive use amongst the rural population" (SSA 1990: 3). Insufficient progress by the family planning program among rural populations is

attributed, among other causes, to the deficient levels of training of service providers: "[P]erformance of service providers in [rural areas] has faced, among other problems, limitations of resources and lack of specific educational materials to promote the program" (SSA 1990: 20).

Mexico's demographic and health policies are currently on a collision course. On the one hand, demographic planning is done with the expectation that programs will meet specific growth and fertility targets. On the other hand, health policies aim to provide integrated reproductive health services to larger shares of the population. Human and material resources available to achieve both aims are insufficient. This is particularly true considering the widening trend to reduce social expenses in the governmental budget. In fact, even with a larger governmental budget, both aims are difficult to reach simultaneously. Further discussion is needed concerning the economics of demographic programs. How will programs be financed? What are the priority populations? What are the priority needs? Policymakers will face these questions in the near future and eventually will have to decide upon an equitable and effective allocation of resources, as well as upon strategies to extend services to larger shares of the population. The demographic future of the country largely depends upon such decisions.

Notes

1. The *ejido* system is a collective nominal ownership of land in which the government grants communities the right to use and exploit a piece of land. Ownership is nominal because community members are entitled to use the land but not to buy or sell. *Ejidatarios* (landowners) are entitled to a piece of land within the area assigned to the community insofar as they are local residents. Each *ejido* has an independent administration but they are organized at the state and national levels. Under this system, post-revolutionary administrations conducted a 60-year-long agrarian reform campaign to redistribute large private landholdings to peasants and agrarian workers.

2. McCoy's perspective is enlightening to the extent that it attempts to explain population policy formulation as part of the decisionmaking processes within political systems; it thus explains a democratic or semi-democratic process in Venezuela, Costa Rica,

and Colombia, as opposed to an authoritarian process in Mexico, Brazil, and Peru.

3. It is a different matter whether this practice is healthy for both the public and the academic sectors. Some critics question the theoretical worth of demographic estimation *per se*, and the academic value of ad hoc projects and contracts. They argue that universities are meant to do another, theoretical type of research. Conversely, others question the purpose and ethical virtue of relying on academic research to justify post hoc decisions that are made on political grounds. Some argue that the permeability between universities and the public sector is a shared complicity in a vicious cycle of decisionmaking and faulty research rather than a productive partnership in which researchers aim to usefully apply theoretical research and decisionmakers ground policies and actions on knowledge rather than guesswork.

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The Future of Population Policies

What will be the long-range fate of the recommendations contained in the ICPD Programme of Action? Will they have lasting effects on the way population policies are articulated and implemented? The answer to this question requires speculative analysis. Such an attempt is made here, based on past experience in developing countries, especially in the four countries included in this book.

THE ICPD MESSAGE

Contained within the comprehensive document known as the Programme of Action, the main message for improving individual wellbeing comprises two elements: to provide contraceptive methods within broader reproductive health services, and to advance women's equality in education, health, and economic opportunities. The ICPD document does not explicitly link these goals with the reduction of population growth rates. These public policies are justified in their own right, irrespective of their effectiveness in reducing fertility.

Within the "fertility reduction" paradigm, these two elements are consonant with the determinants of unwanted and wanted childbearing. While fertility has declined under conditions of poor reproductive health and extreme gender disparities, the provision of contraceptive services within the context of reproductive health can be expected to reduce unwanted fertility, and movement toward gender equality can be expected to create conditions favorable for smaller families.

There is a good match between what might be termed the women's agenda and the agenda of those interested in reducing population growth, with

one major caveat. The women's agenda treats reproductive health and gender equality as ends of public policies, whereas the population agenda could treat them both as means for population stabilization and as desirable consequences of population stabilization.

Figure 6.1 sketches the typical pre-ICPD design of a population policy and contrasts it with what is desirable post-ICPD. In this view, a country's family planning program is seen to move toward a reproductive health program.¹ Other elements included in family planning programs prior to ICPD, aimed at reducing desired family size or at reducing fertility without altering desired family size, are now replaced by policies oriented to reducing gender disparities. Thus, one of the primary implications of ICPD for population policies is to shift the responsibility for reducing desired family size from a country's family planning program to other sectors of development. This position is also consistent with various theories of fertility decline that postulate desired family size as a function of socioeconomic and institutional factors.

Prospects for Success

There are two reasons for optimism concerning the prospects for the acceptance and implementation of the 1994 strategy: the comprehensive nature of the strategy and a strong alliance among those interested in improving women's lives.

First, the strategy implied by the main message of the ICPD is different from that implied by the slogan "Development is the best contraceptive," coined at the 1974 conference. This slogan implied an exclusive focus on socioeconomic development to usher in the demographic transition, whereas the ICPD strategy implies a more balanced, comprehensive, and humane approach to the reduction of fertility and population growth. The 1974 slogan led to a search for the most cost-effective way to reduce fertility and to a debate regarding development versus family planning as the most cost-effective way to reduce fertility. The ICPD strategy should lead to a more coordinated approach that will optimize the synergistic effects of development, reproductive health, and family planning.

Figure 6.1 Implications of the ICPD for population policies and programs

Pre-ICPD		Post-ICPD
Family Planning Program • Services and information for contraceptive methods	→	Reproductive Health Program* • Make use of contraception voluntary and safe
• Motivational messages • Incentives • Targets • Coercion	→	• Reduce gender disparities in education, health, and economic opportunities

*See endnote 1.

Second, the 1974 conference implied indirectly the need to reduce class disparities by reducing the gap between the North and the South and, by implication, between the rich and the poor within a country. This recommendation found little acceptance in the absence of an alliance across class boundaries, whether within or between countries. The 1994 recommendations have a better chance of success because of a strong alliance across gender, class, and geographic boundaries among those interested in improving the conditions of women.

On the other hand, ICPD makes some very unrealistic demands on national governments. The implementation of a broader population policy as embedded in ICPD recommendations would require a cross-sectoral approach to policymaking. Experience in policymaking with such an approach, however, has not been promising so far, either in the population field or in other fields. At least six factors would hamper implementation of such an approach in any setting. The extent to which these issues are resolved would determine the degree to which a broader population policy is implemented in a country and succeeds in reducing population growth and improving individual wellbeing. These factors are:

1. Lack of conceptual clarity,
2. Disagreement among academics and intellectuals,
3. Concern about losing funds for family planning,
4. Absence of effective bureaucratic structures,
5. Lack of effective accountability mechanisms, and
6. Waning role of government.

Lack of Conceptual Clarity

National governments and international agencies remain interested in reducing population growth in developing countries in order to improve prospects for economic development. A national government will rarely adopt a policy to reduce fertility or population growth that is not in the self-interest of its leaders, that hinders progress toward economic development, or that is inconsistent with its ideology. In the 1974 articulation as well as the recommendations of the ICPD, the goal of reducing population growth is synonymous with the means propagated to achieve those goals—economic development in 1974, gender equality in 1994. Berelson (1978) articulated this linkage as follows:

[T]he objective of the whole exercise is to expedite that [fertility] reduction in order to hasten development; so recommending the latter as a way to achieve the former rather misses the point. (p. 607)

The broadened population policy as embedded in the ICPD recommendations argues for the adoption of development policies that would reduce gender disparities in health, education, and economic opportunities. This would require implementation of gender-sensitive social and economic policies. Hence, in order for gender-sensitive policies to be implemented, the reduction

of gender disparities would need to become a primary goal of mainstream development. The objective of each sector of development—education, health, human resources—would need to be redefined in terms of improving gender equality. While there is some agreement about the desirability of this shift in the goal of development among advocates of women's issues and population issues, its widespread adoption by population professionals would require empirical evidence to demonstrate that the improvement in gender equality is the most cost-effective way to reduce fertility (see, e.g., Basu 1997); and its adoption by development professionals would require empirical studies to demonstrate its contribution to economic development. Even so, the goal of reducing population growth becomes synonymous with the means to achieve those goals. The issue of feasibility aside, more problematic is the competition created by this overlap between means and ends among various sectors of development for resources previously allocated solely to reducing population growth and fertility.

Disagreement Among Academics and Intellectuals

There is little agreement among academics and intellectuals about the relative importance for fertility reduction of various policy responses: diffusion versus development, social versus economic development, female education versus gender equality in education, gender versus class equality, female education versus infant and child mortality versus family planning. To achieve agreement on such issues requires comparisons of relative fertility-reducing effects of investments in such sectors as agriculture, education, health, and family planning. Following the 1974 conference, Simmons (1979) compared the marginal impact of expenditures on alternative interventions to reduce fertility and found that the direct route of family planning programs is more cost-effective than the indirect route of development programs. More recently, Summers (1992) found investments in education to be more cost-effective than investments in family planning.

Such comparisons, however, assume independence between the two types of interventions, which is not the case. The cost estimates of births averted through family planning programs assume that these programs will be equally successful in averting births irrespective of whether or not women want to regulate their fertility, which is not the case. The cost estimates of birth averted through education similarly ignore the lag between the investment in education and the time when its fertility-reducing effect would materialize. The investment in education in high-fertility societies will have little or no effect on the fertility behavior of those women who are already in their reproductive period, while family planning does. The effect of investment in education on fertility is likely to be felt when girls who are now of school-going age enter their reproductive period in about ten years (see Jain 1982 and 1998). The proponents of the education approach are silent on the government's role during this time lag with respect to women who are already in their reproductive period.

Even if the importance for fertility reduction of improving education is demonstrated, second-order questions have to be addressed: whether improvement in female education is more important than reduction in gender disparity in education; whether investment in broadbased primary education should be recommended over a narrower program of secondary education; whether adult out-of-school education is to be preferred to classroom education; and whether to invest in improving the quality of education at the expense of expanding access to educational facilities.² Depending upon the answers, not only would additional resources be required for the education sector, but resources within that sector would have to be allocated differently in order to enhance the fertility-reducing effect of investment in education. Neither of the two strategies is popular; lobbies within the education sector do not like a shift in resources from higher to lower-level education, and the proponents of family planning programs worry that additional resources allocated to education for fertility reduction could have been allocated to family planning programs.

Concern About Losing Funds for Family Planning Programs

Public programs have to compete with one another for funds. Since money for family planning programs is raised on the basis of their effects on reducing fertility, any additional funding for the education sector, for example, could be interpreted as an argument for the transfer of funds from family planning programs. Proponents of such programs would remain concerned that additional resources for female education or reproductive health could mean a reduction of resources for family planning (see, for example, Caldwell 1997).

Absence of Effective Bureaucratic Structures

The bureaucracies of national governments and of donor agencies are divided into various branches, each with its own mandate, constituency, and budget. A policy concerned with reducing population growth and fertility is implemented mainly through a single government department or ministry, while gender-sensitive social and economic policies are implemented by other departments and ministries. Thus agencies responsible for population stabilization or fertility reduction have neither control nor influence over most of the development expenditures that would be required to create conditions favorable for small families.

Within the United Nations system, UNFPA has little influence over the resources allocated for improving child health, female education, or economic opportunities for women. Similarly, the Office of Population within USAID and the departments of family planning or population control in other national governments have no leverage over the allocation of funds required to empower women to exercise their reproductive choices voluntarily.

Consequently, when discussion occurs between a donor and a government about issues related to population policy, it takes place between the department of family planning and the officer in charge of population within the donor

organization. This limits the scope of discussion to the issues related to service delivery. The implementation of a broader population policy would require that such discussions take place between parties responsible for the entire development process. It would then be possible to place the need to implement gender-sensitive social and economic policies on the agenda of both groups—those interested in reducing population growth and those interested in economic development.

Lack of Effective Accountability Mechanisms

There is no bureaucratic mechanism to ensure that development policies adhere to the goal of reducing gender inequality and other disparities in a society. A department of the government assigned to implement the family planning program cannot ensure that development policies pay adequate attention to the reduction of gender disparities and allocate resources required to improve female education and women's economic opportunities. Similar bureaucratic problems exist within the UN system and other major donor agencies.

The implementation of a broader population policy would require a watchdog organization within national and international agencies to ensure that other ministries modify their policies and programs and examine the effects of these programs on gender equality and family-size preferences. It is not certain whether any existing organization within the national and international bureaucracies can play this role. It is also not clear whether a new bureaucratic structure would be more effective than existing ones. Perhaps community-level entities, including women's groups, can evolve into watchdog institutions to ensure accountability in public policies and expenditure, at least at the local level.

The research community can also contribute to the accountability process by monitoring and evaluating development programs. While investment in development sectors can be justified on the basis of their non-demographic effects alone—for example improved education, improved health, economic growth—the effect of these policies and programs on gender disparity needs to be examined in order for these policies to be modified. Moreover, the effect of sector-specific policies and programs on improving gender equality in education, health, and economic conditions needs to be monitored regularly in order for these sectors to be accountable for improving gender equality.

Waning Role of Government in Social Engineering

Beyond the issues of resource mobilization and allocation, and realignment of turf between various sectors of development, the effective implementation of a broader population policy intended to reduce gender disparity and to improve reproductive health assumes a strong role of the government in people's lives. Yet the role of government in social engineering starts waning as developing countries shift from centrally planned or mixed economies to market economies. Moreover, what can be expected realistically from a government as these shifts take place needs to be examined and revised accordingly. Under the socialist pattern of development, governments were expected to provide almost everything—edu-

cation, food, water, transport—to the population. The entire UN system is also built upon the same premise—a strong role of national governments.

But is a strong role for government desirable or even feasible in the area of social engineering? The importance of these issues for population policies will increase over time as developing countries shift to market economies. How gender disparity can be reduced under these changing circumstances is an issue that needs to be addressed by both population and development professionals. Although a government's commitment to the ideal of equality of opportunity is essential, it is equally necessary to achieve the commitment of the private sector to the ideal of offering equal opportunities to all individuals irrespective of gender, race, religion, caste, or tribe.

PRACTICAL STRATEGIES

Population policies in developing countries have often been equated with family planning programs. The implementation of the ICPD agenda would blur the distinction between population, health, and development. The problem is both semantic and real. It is semantic because the word "population" at the policy level is replaced by "family planning" at the implementation or program level. It is real because the sole responsibility for implementing a population policy is assigned to one department of the government, while the actual implementation of a population policy cuts across various departments and ministries, each with its own mandate, budget, and constituency. In this sense, a family planning policy could be implemented effectively through a family planning program; but neither a population policy nor a fertility-reduction policy could be implemented in this manner.

The relationships between a population policy, a family planning program, and reproductive health can be examined under various scenarios, three of which are discussed here. The first scenario is to retain the narrow interpretation of population policy as fertility reduction through family planning programs. The second is to equate population policy with a reproductive health policy, and to expand the scope of family planning programs to incorporate all reproductive health services. The third scenario is to equate population policy with a development policy, and to further expand the arena of population activities to influence all sectors of development.

How far a country's population sector will move from the pre-ICPD situation will depend upon the basis on which resources for the population sector are mobilized and the way these funds are allocated.

The overriding intent of national governments and international donors in allocating funds to the population sector has been to reduce fertility and population growth. If that continues to be the case, it would be difficult to move beyond the pre-ICPD situation at the program level, unless a shift of emphasis toward reproductive health is demonstrated to be a cost-effective way to reduce fertility.

Equating population policy with a reproductive health policy is likely to result in problems of resource mobilization and allocation, especially in an era

of prioritization of public health services. While improvement in the reproductive health of individuals through provision of reproductive health services is a laudable goal, a second generation of important issues will have to be addressed. These issues include: which ministry or department should provide and pay for reproductive health services and why? how should it provide these services? and should family planning programs be equated with or replaced by reproductive health programs?

The reproductive health approach is driven by individual rights and well-being. The implementation of programs according to this vision will depend upon the extent to which governments and donors subscribe to these ideals and start allocating funds to these programs on the basis of individual well-being. In cases where funds for reproductive health programs are allocated for the purpose of reducing fertility, the addition of specific reproductive health services to the ongoing service delivery program would have to be justified on the basis of its contribution to fertility reduction. Moreover, to ensure sustained interest in the improvement of reproductive health, this approach has to be demonstrably more cost-effective than the delivery of contraceptives alone in terms of fertility reduction.

Equating population policy with a development policy would mean that either population is subsumed within development or development is subsumed within population. The first alternative will not be accepted by the population field for fear of population issues getting a low priority and family planning programs losing funds. The second alternative implies that the population problem is treated as the principal problem, which is like putting the cart before the horse. This premise is most unlikely to be accepted by those who control resources for development, especially since fertility has declined and continues to decline under various conditions, including economic hardship, extreme gender disparity, and adverse reproductive health.

What is a practical strategy for the population field and, in particular, for those who remain interested in the reduction of population growth and fertility? First, we need to avoid semantic problems by making a distinction between a policy and a program, and by making the objective of a policy consistent with the design and the main criteria of evaluating the success or failure of the corresponding program. At the policy level, we need to distinguish between "population," "fertility-reduction," "reproductive health," and "family planning" policies. At the program level, we then need to recognize that a family planning policy can be implemented through a family planning program and that it will contribute to the reduction of population growth and fertility by reducing unwanted childbearing. But the implementation of a fertility-reduction policy would require the involvement of other sectors of development in reducing gender and other disparities rather than in the delivery of contraceptive services. Thus, a lack of progress toward fertility reduction in a country might reflect not only the ineffectiveness of its family planning program in reducing unwanted childbearing but also a lack of progress made by the other sectors of development in creating conditions conducive for small families.

Second, we need to recognize that the delivery of reproductive health services cannot become the sole responsibility of family planning programs. Reproductive health advocates will have to work with both family planning and health departments to ensure that a complete package of reproductive health services is delivered. One way to accomplish this goal is to advocate that those reproductive health services that interact directly with the reduction of unwanted childbearing are paid for and delivered through family planning programs, while other aspects of reproductive health become the responsibility of health programs. In this case the purpose of family planning programs would have to be revised from the reduction of *total* fertility to the reduction of *unwanted* childbearing in a healthful manner. The addition of the phrase "in a healthful manner" explicitly to the purpose of family planning programs implies that these programs pay attention to the reduction of morbidity associated with individual efforts to reduce unwanted childbearing. The criteria of program success or failure would be revised from changes in indicators such as total fertility to changes in an indicator such as HARI—an acronym for Helping individuals Achieve their Reproductive Intentions (see Jain and Bruce 1994).

Third, we need to define the goal of a fertility-reduction policy and of a population policy explicitly in terms of improvements in individual wellbeing through a reduction in fertility and population growth. This would mean that we take a public stand against those government activities oriented to reducing fertility that are not consistent with the overall objective of improving individual wellbeing.

Above all, we need to advocate publicly for these changes in policymaking, program implementation, and evaluation. We need to give as much attention to the qualitative issues of people's lives as we give to the quantitative issues of population size and the growth rate. We need to think of population issues as one aspect of a social reform movement for improving individual wellbeing, and we need to establish stronger ties with other social reform movements, including but not limited to the feminist movement. A stronger alliance among various social reform movements should result in better public policies that reduce gender and other disparities.

Notes

1 The delivery of contraceptives is and would remain a central focus of reproductive health programs, which would consist of many other services (for the outline of a comprehensive reproductive health program, see, e.g., Pachauri 1995). However, a family planning program cannot be simply renamed a reproductive health program without, at a minimum, making the use of contraception voluntary and safe (Jain 1995). This

does not mean that other services required to improve reproductive health are unimportant.

2 Addressing these types of issues does not require comparisons of potential fertility-reducing effects of activities across sectors but would require comparisons of these effects among various options within a sector (see Jain 1982).

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The extent to which effective public policies are articulated and carried out often depends on the degree of political commitment to the ideals imbedded in them. The four country studies in this volume address the question “Do population policies matter?” by examining population policymaking and the politics surrounding it from historical and contemporary perspectives. The countries—Egypt, India, Kenya, and Mexico—were selected because of their demographic weight, a long history of population policies and programs, and evidence of fertility decline.

Each study is based on sources that reflect perceptions of population issues within the country: official documents, public statements, mass media, and religious commentaries. Issues related to the evolution of a population policy include the role of key stakeholders, the influence of internal politics and international agencies, the administrative structures guiding the program and providing coordination, and the degree of flexibility and autonomy at the local level.

An introductory essay offers observations on the politics of fertility transition over the past several decades, while a concluding essay speculates on the future of population policies.

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